

LOGAN COUNTY

Respite Protocol

Purpose: Diverting Juvenile Detention Center, Residential, and Foster Care Placement

In order for an active Child and Family Team to request respite for a family, the following conditions should be met:

1. Child/youth has not been charged with delinquency and/or continued current JDC placement not appropriate; or
2. Child/Youth can not return/stay home because
 - a. Family stability depends on the separation of family and child/youth when the level of stress is excessive (including impending risk of out of home placement), or
 - b. Circumstances leading up to removal are not primarily due to child's/youth's issues (including homelessness and safety issues and/or risk of harm), and
3. Documentation that all family/kinship/relative options have been explored and found not appropriate. List child paternal/maternal parents, grandparents, adult siblings, aunt & uncles on CSB placement search fact sheet. (or attach previously developed genogram)
4. If Family Select Provider is available to provide respite services, if so, follow "Process for using Family Select Provider Respite." If Family Select Provider can not be identified, then follow "Process for using Licensed Foster Care Respite."

Process for using Family Select Provider Respite

1. Lead Worker to determine who the Family Select Provider will be and register that provider with either the Family & Children First Council or Board of Developmental Disabilities (whomever will be paying the provider) as outlined below
 - a. FCFC Family Select Provider
Send to FCFC the Family Select Provider Registration/Release form provided in Attachment K along with the Funding Request form provided in Attachment C.
 - b. BDD Family Select Provider
Send to FCFC the Funding Request form provided in Attachment C that indicates the vendor information (IE: BDD). Vendor will pay provider and bill FCFC (typically via a shared funding agreement).
2. FCFC Program Coordinator will bring Funding Request to Triage for review.
 - a. If Approved for FCFC Family Select Provider, will send a letter and reimbursement form to provider and copy the lead worker and parent
 - b. If Approved for BDD Family Select Provider, will notify lead worker of approval, generate shared funding agreement with BDD for a maximum of 3-months and send executed agreement to Lead Worker and BDD.
 - c. If Denied, will inform the lead worker.

Process for using Licensed Foster Care Respite:

1. Lead Worker completes CSB Foster Care Respite Packet (Attachment E) and sends along with the requested dates of respite to CSB by fax (599-7296) and calls CSB foster care unit (599-7290) to verify fax was received.

Note: for ongoing respites completion of entire respite packet is not necessary, just update the Placement Search Fact Sheet quarterly or if a significant change occurs with child/youth health, mental health, behavior, custody, or legal involvement. The entire Respite Packet should be updated with CSB at least annually.

- a. After hours respite requests will be made by providing Placement Search Fact Sheet information orally to the CSB on-call worker who will contact the CSB foster care worker.
Note: Emergency respite for new cases may not be possible to locate.
3. Lead Worker completes FCFC Funding Request Form (Attachment C) and submits to FCFC Program Coordinator by Triage Representative or fax (592-7001).
2. CSB will contact Lead Worker with options (either CSB or contract home) between one and 3-weekdays and ensure required provider paperwork that needs completed is forwarded to lead worker.
3. Lead worker will complete, securing custodian signatures if indicated and provide copies of the provider paperwork to CSB. At a minimum, paperwork will include:
 - a. Copy of the child's medical card or proof of insurance
 - b. Medical consent to treat form signed by the custodian of the child/youth
 - c. Crisis Plan (to be reviewed between lead worker and respite provider prior to placement)
4. Lead Worker will be responsible for coordinating transportation of the child/youth to the respite home. Will also ensure ongoing communication with the Parent/Custodian of child/youth.
5. CSB FC Facilitator will ensure ongoing communication with the Foster/Respite Parent.

Funding:

Lead worker submits Child & Family Team Funding Request form to the FCFC Program Coordinator for Triage review. If the request is approved, the FCFC Program Coordinator will mobilize a shared funding agreement using the following funding streams:

- a. Family Centered Support Services Dollars
- b. Local Pooled funds
- c. FCFC will contact agencies working with child/youth and asked to contribute a portion of costs

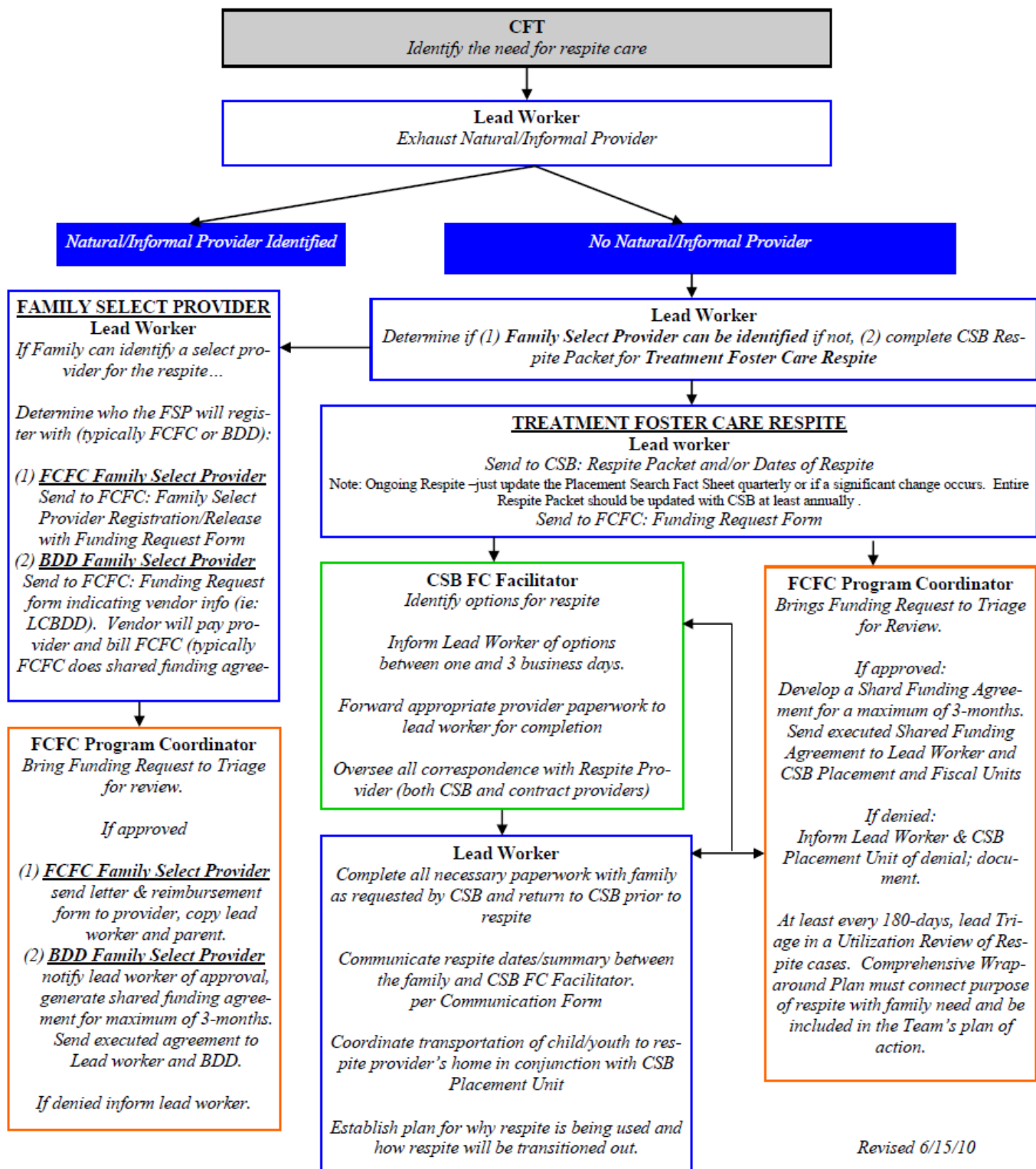
A fiscal agent will be determined for the shared funding agreement.

Guidelines:

1. Within three weekdays following the first day of emergency respite, a team meeting will be coordinated by the lead worker to develop or revise the family's Comprehensive Wraparound Plan.
2. Respite should be used as an intervention that includes a team evaluation/review of its successes and plan to prevent the use of respite in the future. Child abuse issues should be referred to Children's Services. Other safety issues should be referred to law enforcement or Family Court if child/youth is currently under supervision.
3. Triage will be paneled within 5-business days of the start of an emergency respite to review the case and respite funding. If there is not an established Child & Family Team, a referral will be made to the Family & Children First Council on the next business day to schedule a meeting within 72-hours.
4. Youth are to return to the family home at the end of respite unless significant safety issues are clearly present. If significant safety issues are present, Kinship options will be vigorously pursued by the lead worker.
5. Respite should never exceed 10-days during one respite session unless involved agencies agree.

Logan County Respite Protocol

Communication Flow Chart



Revised 6/15/10

**Respite Use of Logan County Children's Services
Licensed Family Foster Homes**

To: _____ **From:** _____

Fax #: _____ **Re:** _____

The following forms **must** be completed and faxed to Logan County Children's Services prior to placement at (937) 599-7296, Attn: Libby McClure. The lead agency is also responsible for providing a copy to the foster parent at the time of respite.

Required documentation to be completed:	
	Respite Search Fact Sheet
	Right to Treat/Transportation Form
	Consent to Treat Agreement
	Medical Insurance Coverage Agreement
	Copy of Medical Card/Proof of Insurance
	Copy of Genogram
	Copy of Crisis Plan

Instructions for Completing Respite Forms

- 1.) **For the Respite Search Fact Sheet-** Please make sure that all of the areas on the Fact Sheet are completed. If the area is unknown, obtain the information from the family, etc.
- 2.) **Medical card/proof of insurance-** A copy of the child's medical card or proof of insurance needs to be submitted with the rest of the respite forms.
- 3.) **Genogram-** A genogram of the family also needs to be submitted with the rest of the respite forms. The genogram should contain at least the following items: 3 generations of family members and the names and addresses of the family members (see attached genogram information).
- 4.) **Crisis plan-** If there is a crisis plan, the plan needs to be submitted with the rest of the respite forms.

Office Use:

	Date	Workers Initials
Packet Received	_____	_____
Client Status Completed	_____	_____

RESPITE/PLACEMENT SEARCH FACT SHEET AND AGREEMENT

INFORMATION ABOUT THE CHILD

Child's name: _____ DOB: _____ Age: _____
 Race: _____ Child's SSN: _____
 Current location of the child: _____
 Person completing form: _____ Date: _____

Presenting Problems: *past or present*
 (check all that apply to child)

Past	Present/Last 3 Months	
___	___	Sexually abused Perpetrator's relationship to child:
___	___	Physically abused Perpetrator's relationship to child:
___	___	Neglected Perpetrator's relationship to child:
___	___	Inappropriate sexual behaviors Describe:
___	___	Sex offender Adjudicated?
___	___	Encopresis
___	___	Enuresis Day wetter, Bed wetter?
___	___	Aggression (verbal/physical) Towards others, who?
___	___	Animal Abuse
___	___	Anger management problems
___	___	Lying
___	___	Stealing
___	___	Runaway
___	___	Truancy
___	___	Sleep disorder Medications?
___	___	Eating Disorder Past Tx?
___	___	Fire Setting
___	___	Authority Issues With women, With men?
___	___	ADD/ADHD Medications?
___	___	Alcohol and/or drug abuse Please describe:
___	___	Smoker (smoking should not be permitted for a youth under 18)
___	___	Suicidal Ideation Please describe:
___	___	Self-esteem problems
___	___	Hygiene problems
___	___	Other (please specify)

Is the child on probation? _____ If yes, who is their probation officer? _____
Why are they on probation? _____

If the child has been adjudicated delinquent, please describe the act that resulted in the child being found delinquent, and the disposition made by the court: _____

Please give any information on any violent acts committed by the child: _____

Child's personality (please try to consider activities the child enjoys and list some good characteristics as well as the negative) _____

Health Considerations

Name of doctor: _____ Name of dentist: _____

___ Allergies (please specify...food, medications, etc.) _____

___ Physical/Health Problems (please specify) _____

___ Currently on Medications (please specify, including dosage) _____

Does the child have any problems (such as allergies or asthma) that would prevent him/her from being placed in a foster home with animals/smokers? _____ If so, please describe: _____

Child's approximate height _____ Approximate weight _____

School Information

Home school: _____ Current School: _____

Grade Level: _____ Program: (LD, SBH, MR, etc.) _____

Academic performance? (A's, B's, C's, etc.) _____

School behavioral issues (including peer relationships) _____

Counseling

Is the child currently in counseling? _____ With whom? _____

Contact telephone number: _____

Has the child had a psychological evaluation and/or assessment in the last year? _____

If so, date _____ Completed by? (name and agency) _____

What is the current diagnosis, if any? _____

Please attach conclusions and recommendations of the psychological evaluation.

Visitation

Is the child allowed to have contact with birth family members or friends during respite? _____

Please list restrictions _____

Setting

Are there any restrictions that would prevent the child from being in a home with other children? _____ If so, please describe: _____

Are there any restrictions that would prevent the child from being in a single parent home? If so, please describe: _____

Other pertinent information: _____

Financial Arrangements

The current foster care per diem for children ages birth-4 years old is \$28.00 a day, 5-12 years old is \$26.00 a day, and 12-18 years old is \$30.00 a day. This is for Logan County Children’s Services foster homes only.

Emergency Procedures

The foster parents should contact _____ if there is a problem with the child during this respite at the following number(s) _____

By signing below, we agree that this information is accurate to the best of our knowledge and that we will be available if the foster parent should need to contact us during this respite.

Lead Worker Signature

Date

By signing below, we acknowledge that this information was shared with us prior to agreeing to provide respite for the above named child.

Foster Parent Signature(s)

Date

By signing below, we agree to the provision of respite care by _____, licensed by Logan County Children’s Services.

Foster Parent’s Address: _____

LCCSB Staff Signature

Date

**Respite Use of Logan County Children's Services
Licensed Family Foster Homes**

Right to Treat

As the parent/guardian of _____, I agree to allow Logan County Children's Services to treat him/her, using various resources of the agency, as appropriate. I also authorize Logan County Children's Services to sign for emergency medical treatment in the event I cannot be reached. I accept financial responsibility for all medical expenses.

Non-Prescription Medications

I authorize the Logan County Children's Services foster parent, or staff member to administer minor treatment (the normal treatment that would normally be administered at home), if the need arises.

Transportation

As the parent/guardian of _____, I give my permission for him/her to travel with a Logan County Children's Services staff member or Logan County Children's Services foster parent.

This consent expires the date of discharge unless an earlier date is specified.

Parent/Guardian/Custodian

Relationship to Youth

Date

**Respite Use of Logan County Children's Services
Licensed Family Foster Homes**

The undersigned being the legal custodian of _____ and having entered into an agreement with Logan County Family & Children First Council, hereafter referred to as FCFC, under the terms of which they have entrusted the care of the above youth, and under terms of which FCFC has accepted such care, do in consideration for the signing of such agreement, authorize FCFC to arrange with Logan County Children's Services for respite placement of the above youth, not to exceed 10 days:

- 1.) Acquire or provide any and all routine medical, dental and psychiatric care, treatments and medication prescribed by a licensed physician, psychiatrist or dentist; including any necessary diagnostic tests and immunizations with prior approval of the parent/guardian when applicable.
- 2.) Take whatever steps necessary to aid said child should a medical or dental emergency arise, including but not limited to providing consent for the administration of anesthesia and the performance of any emergency operation or medical procedure found necessary by competent medical examination.
- 3.) Provide consent for appropriate school activities in which said child participates with prior approval of the legal custodian when applicable.

With initial here _____, I understand that I have the right to withdraw my consent at any time.

Legal Custodian

Date

**Respite Use of Logan County Children's Services
Licensed Family Foster Homes**

The undersigned being the legal custodian of _____, and having entered into an agreement with Logan County Family & Children First Council, under the terms of which they have entrusted to its care their ward, and under the terms of which FCFC has accepted such care, do in consideration for the signing of such agreement,

- 1.) Authorize Logan County Children's Services to acquire and/or provide medical treatment for said child
- 2.) Authorize the submission of billing for treatment as follows:

Please check all appropriate boxes and fill out the needed information:

- MEDICAL CARD # _____
Copy of card enclosed yes no, sending later
County Issuing Card: _____
- Youth is Medicaid eligible and a Medical Card is pending
- Youth is covered by other medical insurance (which shall be billed as primary)
Insurance Company Name: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Mental Health/Substance Abuse pre-certification (tel.) _____
Policy #: _____ Effective Date: _____
Enrollee's Name: _____ D.O.B.: _____
Enrollee's SSN: _____ Employer: _____
- Deductible is to be paid by: _____

If third-party coverage is unavailable (including absence of actual medical card causing medical/dental provider to refuse to treat) at any time during placement, the legal custodian do hereby assume responsibility and authorize the medical/therapeutic provider or Logan County Children's Services to submit the proper billing for services rendered to said child to the following address for payment:

Name of Placing Agency/Parent: _____
Attn: (e.g. Fiscal Department): _____
Mailing Address: _____
City, State and Zip Code: _____

Legal Custodian

Date

**Respite Use of Logan County Children's Services
Licensed Family Foster Homes**

COMMUNICATION PROCESS

Communication Process and Responsibilities

- 1) The lead worker is the single point of contact for the family requesting respite.
- 2) The CSB Resource Care Facilitator will be the primary point of contact for the Resource Family and/or Purchased Care Agency. Contact information for the Resource Care Facilitator:
Libby McClure Agency phone: 599-7290 Agency Fax: 599-7296
Email mcclue@odjfs.state.oh.us Cell: 937-210-0748

I. Initial Request:

- a. The lead worker and family will complete the respite packet and identify how often respite is requested.
- b. The lead worker will communicate with the family to determine requested respite dates.
- c. The lead worker will submit the respite packet to the Resource Care Facilitator, when possible at least one week before requested respite.

II. For Emergency Respite:

- a. The lead worker will contact the Resource Care Facilitator, as soon as possible with request (include times for drop off and pick up).
- b. The lead worker will communicate with the family requesting respite, assure transportation, and assure that the child has all required items for respite (clothes, hygiene supplies, medications).
- c. The Resource Care Facilitator will work to identify a Respite Provider and will provide the lead worker with the Respite Providers contact information and arrangements for the respite.

III. For Ongoing Respite:

- a. The lead worker will communicate with the family requesting respite to identify requested respite dates.
- b. The lead worker will provide the Resource Care Facilitator with requested dates at least two weeks prior to the requested dates.
- c. The Resource Care Facilitator will confirm arrangements with the Respite Provider and provide confirmation and any additional information to the lead worker.
 - i. NOTE: Families requesting respite should not be arranging respite dates directly with the Respite Provider.

FAMILY SELECTED PROVIDER REGISTRATION

NAME OF PROVIDER: _____

ADDRESS: _____

PHONE NUMBER: _____

Is this person related to you?	Yes___	No___
Does this person live in your home?	Yes___	No___
Has this person cared for your family member on previous occasions?	Yes___	No___
The hourly rate you will be paid:	<u>\$3.50</u> per hour	
	<u>\$35</u> per day	

Provider Signature

I understand that the Logan County Family & Children First Council has not trained the above mentioned person. Nor has the individual's home been certified as a respite home. The Logan County Family & Children First Council is in no way responsible for the care of my family member when services are being provided by this provider, and I shall hold the Logan County Family & Children First Council harmless of any and all liability of any nature whatsoever associated with this provider rendering services.

Parent/Guardian Signature

Date

FOR OFFICE USE ONLY

Approved _____

Date received _____

By: _____

Director of Logan County Family & Children First Council

Reason if not approved _____

LOGAN COUNTY FAMILY & CHILDREN FIRST COUNCIL

Respite Care Liability Release

I understand that the Logan County Educational Service Center (on behalf of the Logan County Family & Children First Council) is working as a coordinator to provide the distribution of State Support Services funds to local individuals. In order to utilize the interagency funds, I agree to and understand the following:

1. All respite care providers, both family recommended and board approved, are self-employed and answer directly to the parents/family for whom service is provided.
2. Providers are not Logan County Educational Service Center (on behalf of Logan County FCFC) employees while providing respite care, and they are not covered under any type or form of insurance or worker's compensation, nor any other benefits of the Logan County Educational Service Center which is offered to its employees.
3. Providers are personally responsible to report and pay taxes, tips and other fees to the I.R.S., as necessary.
4. In the event of illness or accident, Logan County Educational Service Center is released from liability.
5. All board contracted Providers receive forty (40) hours of training or equivalent and must be certified in CPR and First Aid. Out-of-home Board Approved Provider must also meet home safety and fire inspections.
6. Family Recommended Providers have no training requirements. However, training may be available at your request. The family understands that they are waiving all training and inspection requirements by choosing a family recommended provider.
7. Furthermore, it is the family's responsibility to hire respite care providers to arrange for scheduling of respite care, not Family & Children First Council.
8. When choosing a family selected provider, the family shall assume responsibility for the health and safety needs of the individual family member and further understand that the Logan County Educational Service Center shall incur no liability.

I have read the above statements and understand and agree to this liability release.

Family Member/Parent/Guardian Signature

Date