APPENDIX 2.4.f
SERVICES FOR CHILDREN AND ADOLESCENTS IN PROTECTIVE SERVICES AND JUVENILE JUSTICE SERVICES NEW MEXICO CHILDREN, YOUTH AND FAMILIES DEPARTMENT

I. CHILDREN’S BEHAVIORAL HEALTH SERVICES (STATE GENERAL FUND)

Preface: Many children in New Mexico are income-eligible for Medicaid coverage. Therefore, all these children are eligible for the menu of Medicaid covered behavioral health services, if they meet medical necessity. If they are Medicaid eligible, every effort must be made to access and provide services through Medicaid before State General Funds are accessed. There are a subset of children who are not income-eligible for Medicaid coverage. The State General Fund administered by the Children, Youth and Families Department (CYFD) is, in part, designated to partially meet the needs of the non-Medicaid eligible children and those other sub-populations described below.

Almost all children in the legal custody of CYFD Protective Services and a majority of children/adolescents that are involved with CYFD Juvenile Justice Services are Medicaid eligible. The medically necessary services needed by the CYFD-involved Medicaid eligible population must be provided through Medicaid. Other non-medically, but clinically, necessary services or services that are not provided by the Medicaid menu of services that are allowable under CYFD funding, may be provided to this population dependent on meeting eligibility and criteria and the availability of funds.

A. Target Population and Eligibility

Funding is provided on behalf of children/adolescents, age birth to 21, who are diagnosed with (or who are at risk of developing) a serious behavioral/neurobiological/emotional (SED/NBD) disturbance. This is defined as a DSM IV/ICD-9 diagnosis.

Target populations to be served through CYFD community-based children’s behavioral health services are identified and defined by CYFD as follows in priority order:

1. Children (and their families) referred by, or involved with, Children, Youth and Families Department’s (CYFD) Protective Services (PS) and/or Juvenile Justice Services (JJS) and/or Tribal Social Services. Children involved with PS, JJS or Tribal Social Services may receive services up to the age of twenty-one (21). “Referred by” means children, youth and families who have been formally referred by the county Protective Services or the Juvenile Probation/Parole office or the Tribal Social Services. “Involved with” means individuals and families who have an open case with PS, JJS or Tribal Social Services.

2. Children up to age twenty-one (21), and their families, at high-risk for services and at high-risk for entry into CYFD’s Protective Services, Juvenile Justice Services and/or Tribal Social Services. The following are contributing factors that define the population:
• Severe behavioral, emotional, neurobiological problems/disorders or at risk of developing severe emotional/behavioral/neurobiological problems/disorders;
• Intention/plan to hurt self or other(s) as evidenced by written, verbal and/or behavioral indicators;
• Parent suicide attempt during the past year;
• Substance abusing behaviors by child or their parents;
• Multiple delinquent acts or law enforcement contacts by child;
• Multiple school problems, including suspension or expulsion from school during last year;
• Homeless/runaway;
• Child or parent with mental illness;
• Parents who are incarcerated, involved with the criminal justice system, on parole or probation;
• Physical, sexual, emotional abuse or neglect of the child (current or known history);
• Multi-generational history of familial maltreatment, neglect or abuse;
• Involvement in a teen pregnancy during past year (or) a teen parent;
• Child/youth experiencing cultural, sexual and/or gender identity issues;
• Witness (or participant) to violence in school or community;
• New or shifting family situations/environments that cause psychological distress, stressful family situations, individual/family challenges;
• Death of a family member or close friend during the past year.
• Families in Need of Services (FINS) as defined by New Mexico State Statute, Children’s Code, Article 3, Family in Need of Services Act, Section 32A-3A-2.

B. **Family Involvement**

The Contractor will ensure that families will be full collaborators in treatment planning and service delivery with a focus on the family as the change agent. Giving up on families or labeling them as unmotivated or resistant is not acceptable; it is up to the SE to ensure that the treatment provider develop appropriate mechanisms for client and family engagement, retention, and satisfaction with services.

II. **FLEXIBLE FUNDING (WRAPOURND SERVICE AGREEMENT — STATE GENERAL FUND)**

The Contractor shall provide flexible funding for services that support wraparound approaches. Funding allows for delivery of highly individualized treatment of behavioral health services for children and adolescents meeting the eligibility criteria. Services are primarily community based to prevent out-of-home placement, but out-of-home placements may be funded on a very limited basis as outlined below.

The Contractor shall develop a prior authorization and utilization management system for wraparound funding to be approved by CYFD.
The Contractor shall not reallocate funding and/or change target populations served without approval from CYFD. The Contractor shall track target populations served and expenditures by each service category.

A. Definition of Wraparound

Wraparound is defined as a community-based, strengths-oriented, highly individualized planning process aimed at providing services to children with SED/NBD and behavioral disorders across all life domains within their normal environment. The process will involve the family and embrace a philosophy of unconditional care. Other characteristics of the process include interagency coordination and flexible, non-categorical funding.

B. Target Populations

1. Non-Medicaid children/adolescents involved with Protective Services (PS) or Juvenile Justice Services (JJS);
2. Non-Medicaid eligible children;
3. Medicaid-eligible children/adolescents involved with PS or JJS in need of services not funded by Medicaid;
4. Medicaid-eligible children/adolescents in need of services not funded by Medicaid.

C. Eligibility

Wraparound funding is provided on behalf of children/adolescents, age birth to 18, who are diagnosed with a serious behavioral/neurobiological/emotional disturbance. This is defined as a DSM IV/ICD-9 diagnosis along with a risk of out-of-home placement and current functional impairment.

Young adults, ages 18-21 may be served where no other funding is available to provide these services.

D. Services include, but are not limited to:

Non-Medicaid Services such as:

- Home-based services
- Alternative therapies (i.e. Native American sweat lodge,)
- Religious/spiritual activities
- Language interpreters (i.e. Spanish, ASL, etc.)
- Multi-Systemic Therapy (MST)
- Intensive outpatient
- Respite
- Shelter Care
- Transitional Living Services/Semi-Independent Living
- Tutoring (if not eligible for special education services)

OR
Treatment Foster Care (TFC) Room and Board - TFC room and board payments will be a shared cost between CYFD, SE, legal guardian and other funding sources. WSA will not pay TFC room & board for children receiving Supplemental Security Insurance (SSI) benefits. If the child is receiving SSI benefits, this monthly income shall be applied toward R&B expenses. Upon admission, it is the responsibility of the providing agency to verify whether a child is receiving SSI and/or makes arrangements with the legal guardians for room and board payment.

OR

If there is absolutely no other funding source available:

- Non-JCAHO RTC services and Treatment Foster Care services. Recipients of wraparound funding for residential services (RTC & TFC) will be required to submit documentation indicating they have applied for Medicaid category 032 and/or presumptive eligibility. The maximum reimbursable period will be 31 days, or until the first day of the month following placement, whichever is shorter. On the first day of the month following placement, wraparound funds will not be available for residential services, regardless of the reason of Medicaid ineligibility.

Funding for RTC and TFC services for more than the thirty-one day limit may be authorized on a case-by-case basis when it is the only service that will meet the needs of the child. Due to limited funding, it is expected that these placements will be limited in quantity and duration.

E. Additional Supports Allowable

These items are aimed at addressing specific psychosocial stressors affecting the child's current functioning and reducing the likelihood of out-of-home placement. Concrete items may include, but are not limited to, the following:

- Payment of utility bills
- Speech and language therapy for Autism Spectrum Disorder (ASD) diagnosed children
- Clothing/school supplies
- Eye glasses
- Computer/programs
- Recreational Items
- Housing costs
- Ankle bracelets/monitors

These items and supports are generally provided on a short term and/or one time basis.
III. CARE COORDINATION, CLIENT SUPPORT SERVICES AND COORDINATION WITH PRIMARY CARE FOR CYFD TARGET POPULATIONS

A. Care Coordination

The Contractor shall provide care coordination services to facilitate timely access to and utilization of appropriate services to non-Medicaid eligible CYFD target populations, especially those with high or special behavioral health needs. Care coordination will actively involve children and their families throughout the decision making process from initial planning through implementation and evaluation.

The Contractor shall work with CYFD to develop criteria for identification of persons with high need and or high risk of high utilization, multi-system involvement, multi-provider services or out-of-home placement. The criteria will include such factors as acuity, need for multiple services, past high usage, risk of out-of-home placement and customers transitioning from facilities to the community, from one level of care to another or from the children's system to the adult system.

The Contractor shall also work with CYFD to develop processes to initiate care coordination with these customers and families. These criteria and processes shall be approved by CYFD and the Collaborative.

The Contractor shall identify the organizational structure, qualifications of staff and persons responsible for care coordination to CYFD populations. The Contractor shall also develop a process for communicating to customers and families the availability of and process for accessing care coordination services. The Contractor will clearly communicate to the customer and family the name of the person responsible for care coordination services.

B. Client Support Services

Client Support Services (case management) is a reimbursable service under CYFD funding for non-Medicaid-eligible clients (see crosswalk from SDM to service definitions).

The Contractor shall ensure the provision of client support services to the non-Medicaid eligible CYFD target populations to promote coordination of behavioral health treatment with school and related social services.

The Contractor shall work with CYFD to determine criteria and processes for referral of non-Medicaid eligible CYFD target populations to client support services. The criteria and processes will be approved by CYFD and the Collaborative. This will include how the Contractor uses client support services to identify and track the clinical home for the customer/family, how a single screening and assessment process and client record will be utilized for each customer/family, how it will be determined when client support services are no longer necessary and how outcomes will be measured. Current client support
service providers funded under CYFD contracts will continue in place for at least six (6) months. Prior to changes in providers for client support services, the Contractor will submit a plan to CYFD for review and approval to ensure statewide access and quality of client support services.

C. Physical Health Coordination

The Contractor will coordinate physical health with primary care. The Contractor will implement policies and procedures for coordination of behavioral health services with physical health care for CYFD non-Medicaid eligible target populations. The Contractor will refer to primary care or other physical health care providers when it is determined in the course of screening, assessment or delivery of behavioral health care services that physical health care services are necessary. The Contractor will determine if non-Medicaid-eligible CYFD customers/families have coverage for physical health care services. If the customer/family does not have coverage for physical health care services, the Contractor will refer to indigent care providers.

IV. SERVICES FOR CHILDREN AND ADOLESCENTS IN PROTECTIVE SERVICES AND JUVENILE JUSTICE SERVICES

The Contractor shall:

- Employ a CYFD-specific liaison.
- Provide flexible funding for services to undocumented children/adolescents.
- Demonstrate and document its ability to comply with requirements as set forth by the U.S. Department of Health and Human Services, Administration for Children and Families, ensuring the existence of an array of services that both assess and address the strengths and needs of children and families. These individualized services must be accessible to families and children in all parts of the State.
- Ensure that, at a minimum, services shall include those that assess the strengths and needs of children and families and determine service needs, address needs to create a safe and stable home environment, enable children to remain safely with their parents when reasonable and help children in foster and adoptive placements achieve permanency.
- Ensure an array of behavioral health services in each region of the State that allows children to be served within the least restrictive setting and in close proximity to their families. For those children that require residential treatment, this includes facilities that may be out-of-state if such a facility can meet the treatment needs of the child and is closest to the child's family.
- Ensure that children and families receiving services under the contract shall overall improve their functioning and the functioning of the identified child in the areas of safety, permanency and well-being.
- Communicate and collaborate with CYFD regional, district and local offices in an efficient, collaborative and comprehensive manner.
- Maintain current evidence-based practices such as Functional Family Therapy (FFT) and Multisystemic Therapy (MST).
Enter into an agreement with CYFD for Medicaid reimbursement for Group Home Services at the CYFD-operated Group Homes.

Recognize CYFD as a Medicaid provider and negotiate an agreement on a FFT service rate that will be consistent with the national average cost of FFT.

Work with CYFD and county detention centers to develop services for Medicaid-eligible clients in detention centers, including screening, assessment and treatment.

Track the number of CYFD children/adolescents served and provide reports identifying the number and percentage of children served in excess of 60 miles from their home community.

Work with the Collaborative to establish targets to be achieved in the second year of the contract for reducing the number of children served in excess of 60 miles from their home community.

Establish and/or support an existing Medical/Behavioral Health Committee to improve coordination with an emphasis on behavioral health screens especially for children ages 0 to 3.

Ensure that children in CYFD custody receive a behavioral health screening within 24 hours of a referral for screening, except in emergency situation where the screening is done immediately.

Ensure that the children in CYFD custody receive services at the level of care assessed within 24 hours of the identification of the behavioral health need.

Conduct behavioral health screens for every child/adolescent within 24 hours of entering the juvenile justice system, excluding those who are committed to a CYFD juvenile correctional facility but including those diverted from entering the juvenile justice system, and make appropriate and timely referrals for further assessment and treatment. This will be done in coordination and collaboration with CYFD and county juvenile detention centers.

Have available on a 24/7 basis psychological and/or psychiatric consultation to answer PS and JJS worker questions and concerns regarding treatment, assessments and medications for children involved with CYFD.

Ensure that behavioral health screens and assessments with identification of appropriate services are completed in a manner that complies with the Children's Code Statute and agency timelines.

Ensure that children identified by the PS and JJS worker as requiring emergency psychiatric evaluation and behavioral health services are assessed immediately and that services, including crisis response, are provided at the appropriate level of care in a timeframe commensurate with the clinical need and assessment recommendation.

Provide for services at a higher level of care until such time services at the appropriate level of care are available, if services are not available for a child at the appropriate level of care.

Not adopt a standard that children who have been noncompliant or not successful in treatment are no longer eligible for services as long as the child continues to meet level-of-care criteria.

Authorize travel-related reimbursement, when no other resources are available, to transport children to access required behavioral health services, including reimbursement for the appropriate level of supervision.
for the child in transport, such as the use of EMS, and provide payment to support and facilitate the child's parent(s), including foster parents, participation in the child's treatment. Every effort will be made to ensure that this service is also available for children and their families who are not Medicaid eligible.

- Reimburse travel costs for a family, when no other resources are available, to attend a treatment planning meeting when the family’s attendance is crucial to discharge or another treatment priority.
- Work with CYFD children/adolescents/young adults upon discharge or re-entry into the community to reimburse travel costs for a family to attend Team Decision Making meeting when the family’s attendance is crucial to discharge or another treatment priority.
- Reimburse providers, when no other resources are available, at the case management rate for participation in CYFD service. planning, to include but not be limited to team decision making, family group decision-making, and multidisciplinary meetings required for the treatment plan.
- Develop and implement protocols for the administration of psychotropic medication to CYFD children/adolescents and create a review process for children/adolescents prescribed psychotropic medication to detect non-compliance with the protocol.
- Develop and implement provider contracts that encourage providers to treat children and adolescents with evidence-based behavioral management and other means as an alternative to chemical/psychopharmacological interventions.
- Ensure that PS and JJS staff receive evaluations and progress reports from providers in a timely fashion by incorporating statutory and agency requirements for timely reporting into provider contracts.
- Credential appropriately licensed professional staff in PS and JJS to function as providers of assessments and evaluations for PS/JJS clients so that assessments and evaluations performed by these staff will be accepted by the Contractor to determine a level of care.
- Ensure that no treatment decision regarding a child in CYFD custody is implemented without the authorization of the worker, supervisor or CYFD county office manager.
- Ensure that, when a PS or JJS client is the identified client, that the parent/legal guardian/foster parent shall also be offered behavioral health services to benefit that client, such as parenting skills, family therapy, etc.
- Develop and implement services to support the specialized behavioral health care needs of adolescents who are transitioning from the State’s foster care system through emancipation. Services shall be available in all regions of the State.
- Prioritize parents with children in CYFD custody for substance abuse assessment and treatment, if needed, when it is part of the PS assessment/treatment plan.
- Provide data reports to ensure adequate participation of the Contractor and providers in the State’s federal Child and Family Services Review.
- Establish and implement processes, procedures and methods in collaboration and consultation with CYFD to ensure the coordination of services, including discharge planning, and the development of “wraparound” approaches to meet the needs of those children who are under the supervision of, or at risk of becoming involved with CYFD.
Service delivery should be community based, coordinated/integrated services that are evidence-based best or promising practices.

- Develop an array of services that enable children and their families to be served within the least restrictive settings and whenever possible within their communities and regardless of their source to pay for services. Coordinate payment sources for those clients eligible.
- Define specific strategies to improve processes and discourage redundancy in the assessment process for children and youth.
- Work with the juvenile justice system staff to ensure early identification of youth who are engaging in delinquent or high risk factors including exhibiting signs of serious emotional disturbance.
- Consult with juvenile correctional facility staff and participate in the TDM process prior to an adolescent/young adult’s release from a juvenile correctional facility.
- Support existing advocacy agencies to expand family support networks and peer services.
- Provide transitional services for youth and their families that ensure reunification, when possible, and provide stable support for the youth’s social, emotional and cognitive development.
- Require no prior authorization for evaluations performed for children/adolescents/young adults preparing to transition out of a 24-hour facility, including juvenile correctional facilities.
- Identify CYFD-involved youth who have reached age 16 and contact parents, protective service workers, juvenile justice workers, agency care managers and others as appropriate to begin planning for transition.
- Create an individualized set of community services and natural supports for an effective wraparound approach to serve children/young adults and their families so that they can achieve positive outcomes. Include the child/young adult and their family in every step of the process.
- Convene a work group to design and implement effective transitional services to adolescents moving from the youth delivery system into the adult system.
- Develop and maintain semi-independent and independent living services for youth transitioning from adolescence to adulthood.
- Train Family Peers to include curricula devoted to helping families develop the skills necessary to match goals and services and to advocate for the needs of the child and family. Include biological, foster, adoptive and extended family members to identify strengths and resources of the child and family and to build services and supports needed.
- Ensure providers adopt and implement policies related to including families, foster families and youth in treatment planning.
- Not require prior authorization for school-based services; provide on-site support to schools that have an independently licensed mental health professional on staff in need of technical assistance; and develop and implement on-site support for schools that do not currently have these services.
- Work with the Behavioral Health Training Institute to support its development.
- Begin discharge planning with staff within 24 hours of the child’s admission to an acute setting and out of home setting to identify
precipitants to the placement and conditions for the child's return to the community.

- Provide support services with an array of clinical and placement stabilization support services to residential, day treatment, foster and treatment foster care providers to ameliorate the need for psychiatric hospitalization of youth while in these placements.
- Provide information and training to families/guardians and providers who are eligible for EPSDT services about accessing those services. Involve families/guardians as active participants together with Primary Care Providers (PCP) and behavioral health clinicians for the services to be provided.
- Assess the child/adolescent/young adult's emotional, social and cognitive needs and develop a plan of supportive services prior to discharge, which could be immediately implemented upon their discharge. Utilize network providers early in the process to provide assessment and services to divert such types of placements.
- Train staff, providers, and the community in the philosophy and use of wraparound approaches and methods especially when assessing a child/adolescent/young adult.
- Work with juvenile justice services to establish, maintain and evaluate a notification system for 15-day diagnostic evaluations in accordance with court expectations and provide those evaluations within the time frames required by statute, the court or CYFD policy.
- Provide services to Medicaid eligible children/adolescents/young adults when they have been placed in a detention facility, temporary disposition (15-Day Diagnostic Evaluations at YDDC) or a reconsideration commitment status to a facility. Coordinate and reimburse for clinical services.
- Reimburse for court-ordered 15-Day Diagnostic Evaluations performed at YDDC for Medicaid eligible clients. Develop a code for court-ordered evaluations and reports that will not require prior authorization.
- Continue to allow CYFD staff and facilities currently approved for credentialing and billing to function as such during the provider transition period.
- In the Provider Handbook, describe responsibilities and expectation of providers who serve children/adolescents/young adults and families.
- Identify strategies to help strengthen existing family networks and peer services.
- Develop a behavioral health disaster preparedness plan based on the protocol in the New Mexico All Hazard Emergency Operations Plan that includes addressing the needs of CYFD's target populations, those involved with and at risk for involvement with Protective Services, Juvenile Justice and Tribal Social Services.

V. CYFD PERFORMANCE AND OUTCOME MEASURES-PHASE ONE

A. General Outcome Themes as per the Administration for Children and Families, Child and Family Service Reviews (CFSR)
B. General Performance Outcomes Performance Measures

- Improve individual CFARS indexes in Relationship, Emotionality, and Safety.
- Improve the functioning level of the family.
- Improve client satisfaction with services.

CFARS\(^1\)
NCFAS\(^2\)
Youth Services Survey\(^3\)

The outcome measurement process will clearly identify processes and mechanisms by which the Contractor will share data with CYFD.

C. Specialized Services Performance and Outcome Measures

<table>
<thead>
<tr>
<th>Service</th>
<th>Outcome</th>
<th>Measure</th>
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<tbody>
<tr>
<td>Behavioral Health Respite Care (Children up to 19 years of age diagnosed with a serious emotional, behavioral, or neurobiological disorder)</td>
<td>Prevent out of home placements; Provide a therapeutic break for families &amp; caregivers</td>
<td>Track # of temporary and permanent out of home placements; Behavioral Respite Care Impact Questionnaire – every 6 months</td>
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<tr>
<td>Experiential Wilderness</td>
<td>Increase competencies in social, living, coping &amp; thinking skills</td>
<td>Pre/post tests/assessments Completion of Treatment/Service Plan goals</td>
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<tr>
<td>Mentoring</td>
<td>Improve functioning level of child/youth</td>
<td>CFARS Client Satisfaction Survey</td>
</tr>
<tr>
<td>Juvenile/Victim Forensic Evaluations (Court-ordered juveniles up to age 21; or child victims of sex crimes)</td>
<td>To produce forensically defensible socio/legal evaluations related to adjudication and disposition of juvenile offenders or child victims of a sex crime</td>
<td>Customer Satisfaction Surveys (Judges, DAs, JPOs, offenders up to 21 PS Social Workers)</td>
</tr>
</tbody>
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See Procurement Library for data on numbers of clients served and expenditures in last fiscal year.

\(^1\) The CFARS, the Children's Functional Assessment Rating Scale, is mandatory for CYFD agencies/Contractors providing behavioral health services to one or more of the CYFD target populations. The CFARS is required for all identified clients (child/youth ages 5 through 18), and must be scored at intake, every (3) three months thereafter, and at discharge. The Contractor will use the CFARS during Phase One. The Contractor will work with CYFD during Phase 1 to assess the effectiveness of the CFARS as a tool for outcome measurement. The Contractor may decide on another more effective tool for use in Phase Two. Any replacement tool will be approved by the Collaborative.
The North Carolina Family Assessment Scale (NCFAS) (or other approved CYFD instrument) is required at intake, with updates every three months, and at discharge from the agency for those agencies/Contractors who provide Intensive Home Based Treatment/Family Preservation services.

The MHSIP Youth Services Survey (YSS) was developed as part of the State Indicator Project Funded by the Center for Mental Health Services (CMHS). It was adapted from the Family Satisfaction Questionnaire used with the CMHS Comprehensive Community Mental Services for Children and their Families Program and the MHSIP Consumer Survey. The Youth Services Survey is completed at discharge.

VI. CYFD Travel (Transportation)

CYFD’s purpose for the Travel component for CYFD is to offset the cost of vehicle use when providing CYFD contracted services to clients.

Travel/vehicle use reimbursement may be billed for provider staff travels to and/or from a client’s location to provide a CYFD contracted service component.

- Non-client service related travel by provider staff to satellite sites in another city, town or village is **not billable**.

- Travel funds are **not for transporting clients to and from services**.

- Travel funds are **not for transporting provider staff to meetings or conferences**.

The total number of Travel units for a specific agency will be negotiated and limited in the contract.

**Allowable provider staff travel will be reimbursed at a rate of $20.00 per hour per vehicle for travel time. Travel may only be billed to one identified client per vehicle per trip.**

There are some incidents in case management when the transportation of a client or staff is allowable. These situations are included in the reimbursement for case management. Case Management services involve crisis stabilization, advocating, arranging, linking, coordinating, monitoring and/or securing services that may include transporting a client to meet their needs include:

1. Health – physical and mental (i.e. meeting or taking client to the hospital, or a mental health, medical or other health care facility)

2. Personal (i.e. taking a client or transporting a client in order to provide interpreter services for client, etc.)

3. Educational (i.e. attending Individual Educational Plans, school or educational conferences, arranging for tutoring or for GED preparation, literacy and vocational training or educational testing, if needed).
4. Legal (i.e. accompanying client or transporting a client to a restraining order hearing, meetings with attorneys, obtaining legal counsel).

5. Housing (i.e. transporting clients to meetings with HUD, landlords, helping client secure rent, utilities, funds, etc.)

6. Employment (i.e. securing assistance in résumé development, transporting clients to interviews, assisting with job searches and securing employment).

7. Financial (i.e. transporting clients and accessing services that secure assistance with bookkeeping, budgeting, balancing the checkbook, bank reconciliation, taxes, applying for financial assistance).

8. Case Coordination (i.e. Treatment and/or Service Plan coordination with other agencies, such as PS, JJS and/or other service providers involved with mutual clients; attend initial staffing, such as placement review team, when requested by CYFD). Case coordination should occur at least once a month with JPPO or PS staff on mutual clients and may require staff to attend staffing meetings. These activities may include making referrals to achieve a treatment plan objective; phone advocacy on behalf of a client only when it involves a specific outcome identified in the service and/or treatment plan; writing reports or letters on behalf of clients requested by CYFD field staff and/or courts; follow-up on specific objectives identified in the Service and/or Treatment Plan.