IOWA | Health and Human Services

Family Centered Services (FCS) Contract Questions and Answers

Family Interactions

Is there a maximum number of interactions or hours of interactions allowed per case when there are multiple additional parents residing in separate households?

Each additional household is eligible for a referral of up to 4 interactions or 8 hours of interaction per month. Each referral is counted as a separate referral from the primary household. There is no maximum per case as each referral is counted separately.

HHS has allowed for additional parents to have Family interactions. Is the intent to explore other possible placement options or is the intent to establish and/or maintain contact with biological parents?

The purpose of additional authorizations for family interactions for multi-household families is to establish and maintain family relationships. When a child is not able to reside with either parent due to safety concerns, it is essential to work with both parents toward the goal of reunification so that the child can be returned to the care of a parent as quickly as possible.

If a family is going to utilize the additional 8 hours due to there being 2 households, what is the procedure for both JARVIS and FACS? Do we have a separate 3055, and if so, how do we indicate that in FACS?

Currently, the HHS worker will need to manually create a 3055 for the second and any subsequent households when additional FI are needed. Discussion regarding FACS entries is in progress, and the field will be notified if/when changes are made.

In the Provider Portal of JARVIS, the provider only needs to open one line of service for family interactions. All Family Interaction notes should be included in one primary report (monthly progress report or family interactions only report) unless there is a safety concern for sharing information between parents.

For more restrictive placements (Shelter, QRTP, PMIC) are we able to have interactions in place?

Children in QRTP or PMIC placement are not eligible for FCS services. For children placed in shelter whose goal is to return home (i.e. not moving to a higher level of care),

HHS can make a referral for Family Casework to work with the parents. For the purposes of the contact matrix, the child is considered to be in an out-of-home placement and is not required to be seen at the shelter. A referral for family interactions when a child is in shelter placement can be considered on a limited, case-by-case basis and requires SWA and contract manager approval. It is expected that all other options for facilitating contact between the parent and the child have been exhausted prior to considering a referral for family interactions supervised by a provider.

If interactions are going to require traveling will there be a plan to ensure these visits are still happening quickly?

By the end of the PRC, there should be a clear plan for interactions for the two weeks following the PRC. This plan should include the specific dates and times interactions will occur. During that two-week period, it is the responsibility of the provider and family to develop a plan to continue interactions with minimal disruption to the routine.

Can the additional 4 interactions, 8 hours of interaction be added at any point in time?

Yes, a referral for additional interactions may be sent at any point during the case.

If natural supports are doing interactions, does this take the place of the 10/20 for the FCS provider?

No, the interactions supervised by natural supports do not take the place of provider-supervised interactions. When the provider co-facilitates an interaction with the natural support, this does count toward the 10/20 as the provider is making their own observations of the family's functioning. If natural supports are able to provide a large volume of interactions for the family, consider whether it is necessary for the provider to supervise additional interactions separate from the co-facilitated interactions.

Example: Natural support/placement caregiver allows the parent to come to the home and spend time with the children every day after school until bedtime and spend a weekend day at the caregiver's home every weekend. The provider co-facilitates two interactions per month, plus meeting with the parent and children at the caregiver's home for Family Casework. The referral for family interactions should indicate that the provider is expected to provide co-facilitation only at least twice per month. This frees up the provider to provide family interactions to another family who may not have a natural support willing to supervise interactions.

If interactions are provided by natural supports, do we have to refer to the provider?

Yes, the case should be referred for family interactions and the provider should identify that co-facilitation with the natural supports is needed.

Does the co-facilitation count toward the 10/20 for the provider?

Yes. The provider will document their own observations of the family's functioning during the interaction.

Does there need to be a separate interaction plan for each household in a family?

Yes. Each household should have a separate family interaction plan. The circumstances of each household should be considered separately from other households.

08/14/2026 additions

Are natural support-supervised interactions included in the 10/20 max or in addition?

The up to 10 interactions/20 hours of interaction maximum applies to interactions supervised by the FCS provider agency. Interactions supervised by natural supports are in addition to any interactions supervised by the provider and are only limited by the amount of time the natural support is willing to provide supervision. The time the FCS provider spends co-facilitating interactions does count towards the 10/20 max.

Family Preservation Services (FPS)

To ensure the family gets the best opportunity to receive the full 10 days of FPS service, would the agency consider the start date for the following calendar day if a referral is made after 5pm?

When FPS referrals are made after 5pm, the start date becomes the first day the provider makes face-to-face contact with the family. Example: Referral sent at 6 PM, provider is in the area and makes FTF contact at 7:30 PM- the start of the 10 days of services is the date of referral. However, if the referral is sent at 6 PM and the provider makes contact with the family at 10 AM the following morning, the start of the 10 days of services is the day after the referral was made. To minimize confusion, evening and overnight referrals (after 5pm) should be made the following morning.

Family Casework

Would the agency consider shelter placement as group care/QRTP?

No, shelter placement and group care/QRTP placement are two different types of placements. Ending the requirement for FCS providers to see children in out-of-home placement, it was determined that there are times when parents who have children in shelter care are in need of FCS services. HHS will be able to make FMCW referrals on cases when children are in shelter. Family interactions for children placed in shelter will require SWA approval and distance from the home to the shelter will be a primary factor in determining whether FCS-facilitated interactions are needed.

In the initiation phase of the Casework Contact Matrix, at what frequency must each child be seen?

For in-home cases, it is expected that each child is seen at least once per month. Additional contacts with the child will depend on service plan goals for the parents.

For out-of-home cases, children will be seen at family interactions.

In the initiation and service phases for out-of-home cases, is the contractor required to meet with the caregivers/placement?

No, the reconfiguration of the FCS service array is primarily focused on service provision to the parents/legal guardians of the children. FCS providers will not be required to meet with placement caregivers in their homes.

Is the outcome of the Family Functioning Assessment the indicator for when a family can begin moving from one phase to another?

The family functioning assessment, HHS case plan completion, service plan completion, and completing the first FFM will be required to move from the initial phase to the service phase.

Moving from the service phase to the monitoring/preparing for discharge phase requires that there are a structure and consistency to the family's day, the children's needs are being met, the most recent family functioning assessment has not identified any new needs, safety concerns are being appropriately managed through increased parental skills, and that the HHS worker has indicated the case will close in the next 1-2 months.

How do contractors quantify the structure and consistency of a family's day?

Structure and consistency refer to the general routine of a family's day, including responding to the children's needs based on their wake/sleep cycles, attending school, mealtimes, and bedtime. The provider does not need to observe each part of the day but should have a good understanding of the family's day-to-day routine.

Can the crisis response plan be developed during the warm handoff meeting or during the first casework contact with the family?

Yes, the crisis response plan developed at the warm handoff should be primarily focused on the immediate concern that has resulted in ongoing services. When efforts have been made to engage the family in a warm handoff and those efforts have not been successful, the crisis response plan may be developed at the first casework contact.

Days without face-to-face casework contact shall not occur consecutively. Providers do not schedule days of no contact; however, there are times when the family is unavailable multiple days in a row. There are also times referrals are made knowing the family will be unavailable. If these situations occur, not at the fault of the provider, can HHS make an exception?

Exceptions to contract requirements will be considered on a case-by-case basis. Approval will be provided to the contractor in writing and maintained in the file.

Regarding the contract matrix, what is the established protocol for resolving discrepancies when a contractor's assessment of a family's readiness for phase progression differs from the opinion of HHS, the judiciary, or attorneys? What mechanisms or strategies will be employed to ensure continued case progression despite such disagreements?

The FCS provider will be able to move the family from the initiation phase to the service phase after 2 months, provided that a family functioning assessment has been completed, the case plan and service plan have been written, and the first FFM has occurred. HHS may elect to have the family stay at the initiation phase and will need to notify the FCS provider in writing prior to the end of the second month of the case if HHS has concerns warranting ongoing weekly contact with the family. This notification must detail the specific behavioral change that must be observed prior to moving to the next phase of contacts.

Is court separate from the family contact or may it be "part" of it?

A casework contact with a family at a court hearing shall not include time spent in the courtroom for the hearing. The provider is not working with the family during the court hearing, so the time spent in the hearing is not considered casework contact time.

If child is not on the referral sheet and lives in the primary household is there a requirement to see them monthly?

If the FCS provider learns of additional children in the home who are not on the referral face sheet, the provider will need to contact the referring HHS worker to determine whether the additional children need to be seen and if so, request a new referral face sheet that includes the additional children.

Can the FCS minimum 2 contacts in parental home be revised and include parameters of when it may not be safe? Ie. Domestic violence with perpetrator present, parent threatening SWCM/FCS

Exceptions to contract requirements will be considered on a case-by-case basis. Approval will be provided to the contractor in writing and maintained in the file.

Is the IS able to see the client on the same day as an FSS contact or family interaction? For example, can the IS provide SafeCare then have this session immediately followed by a family interaction? The joining of these services is beneficial for teaching and then practicing and is beneficial for service provision in rural areas.

Yes, services may occur consecutively on the same day, particularly if it is supporting teaching and practicing new skills, provided that they are different lines of service. The same service may not be provided in the same household more than once per day, e.g. two FMCW contacts may not occur in the same household on the same day. If two FMCW contacts occur in separate households (parent A's home and parent B's home) on the same day, this is acceptable.

With a new case who has had FPS with CSCs and then a Family Casework referral is made, is a warm handoff still required with the FMCW referral?

A warm handoff would not be required if the same staff who provided FPS will also be providing FMCW. If the plan is to change staff, then a warm handoff is needed.

If the first steps plan and crisis response plan have already been completed during FPS, they do not need to be rewritten.

Can you clarify who is responsible for scheduling the warm handoff meeting for in-home cases?

The HHS worker is responsible for scheduling the warm handoff meeting with the provider and family. The intent of this change is that providers are not "cold calling" families and that the HHS worker is introducing the provider to the family at the warm handoff meeting.

Can family casework be referred at the same time as the PRC?

Yes, this is the preferred method of sending the referral. Parent partner should also be referred for the PRC & the parent partner will attempt to contact the family prior to the meeting to offer services.

Do meetings like the FFM or staffings count toward casework contacts for the FSS?

No.

If there are multiple homes, does this increase the number of casework contacts for the provider?

The number of casework contacts is dependent on the specific needs of each family. There is a minimum number of required contacts for each phase of the contact matrix and additional contacts may be needed to meet the needs of the family. The referral face sheet should specifically identify the goals for each household.

Can family casework be referred when a child is in Shelter/QRTP/PMIC?

A family is not eligible for Family Casework if the child is in QRTP or PMIC placement, unless there are other children in the home in need of services. A family may be referred for Family Casework when a child is in shelter if the child’s goal is to return home after being in shelter placement (i.e. the child is not moving to a higher level of care). The provider is not required to see the child at the shelter.

For Family Casework, is it no new allegations in 3 months or no new founded assessments in 3 months before we can move tiers?

The intent of indicating no new allegations in 3 months prior to moving tiers from service to monitoring/prepare for discharge is that the family has established overall stability- they have a general family routine, structure to their days, maintaining healthy boundaries with others, etc. There may be situations where reports continue to be made but the family is doing well, and the reports are either not accepted for assessment or are spurious in nature, the HHS worker and their supervisor have the discretion to move forward to monitoring/prepare for discharge when they are confident the family is otherwise prepared to move forward.

08/14/2026 additions

Who decides when a family is ready to move from one phase to the next?

When moving from the initiation phase to the service phase, the initial Family Functioning Assessment has been completed, the Case Plan/Service Plan is developed, and the first FFM has been held. If HHS believes that the initiation phase should continue after these parts of the case are completed, the HHS worker needs to notify the provider in writing prior to the end of the second month of services and describe the specific behavioral changes needed to move to the service phase.

When moving from the service phase to the monitoring/preparing for discharge phase, the HHS worker will evaluate the family's overall progress and stability. When it is believed the case will close in the next 1-2 months, the HHS worker will indicate this to the provider so that the last couple of months allows parents to test their independence while having someone available to address any last support needs prior to case closure.

When a case has one child in the home and another child in kinship placement or foster care, how are contact phases considered/documented in the monthly progress report?

The case should be considered an in-home case, with the exception that the child placed out of the home is not required to be seen in that child's placement home. The casework phases should be documented as in-home casework phases on the monthly progress report. The primary difference between the in-home and out of home tracks is that children who remain in the primary home must be seen each month, while children in out of home placement are not required to be seen by providers in their placement. Since this case involves a child being in the home, the safety risk is greater and the child should be seen each month.

SafeCare

Cases have historically been referred for SafeCare services when a parent is in prison or unable to be located and therefore cannot participate. Is there a way to ensure referrals made are appropriate for the service? Additionally, SafeCare fidelity is based on completion of the entire program, we have experienced families being referred and told they only need to complete a particular module. Can the expectations be all referrals are for the entire curriculum and that families are given the opportunity to fully complete the service.

Current expectations are for SafeCare referrals to be made when a parent has the stability to fully participate in the SafeCare program. Ongoing communication occurs with HHS staff indicating that families should only be referred to SafeCare with the intention of completing all three modules. These expectations will continue into the new contract cycle.

Is the IS able to see the client on the same day as an FSS contact or family interaction? For example, can the IS provide SafeCare then have this session immediately followed by a family interaction? The joining of these services is beneficial for teaching and then practicing and is beneficial for service provision in rural areas.

Yes, services may occur consecutively on the same day, particularly if it is supporting teaching and practicing new skills, provided that they are different lines of service. The same service may not be provided in the same household more than once per day, e.g. two FMCW contacts may not occur in the same household on the same day. If two FMCW contacts occur in separate households (parent A's home and parent B's home) on the same day, this is acceptable.

If a child welfare case is closing because the concerns have been resolved but the family wants to continue with and complete SafeCare, can this still be done?

Yes. Follow the established procedure for closing the agency SafeCare case and referring the family to non-agency SafeCare.

Family Focused Meetings (FFM) and Post-Removal Conferences (PRC)

Will the agency provide a referral at 6 months and every 6 months after for an FFM?

No, timelines for FFMs shall be based on the initial referral for family casework. Separate referral forms will not be provided as FFMs are considered a core piece of casework to be completed.

Is it the expectation of HHS that a referral for a Post-Removal Conference be made the same day as removal? Would HHS consider modifying the language to state that the PRC must occur within five calendar days of the contractor receiving the referral? If not, what is the minimum notification time HHS expects providers to receive for PRC meetings scheduled by HHS?

HHS workers are expected to make a referral for the PRC at the time of removal. For late night removals, the worker may elect to send the referral the following morning. The PRC must occur within 5 calendar days of the child being removed from the home. PRCs will generally be on set days/times for ease of scheduling.

Would the Agency agree that, if there is documentation showing that HHS canceled a Family Focused Meeting (FFM), the cancellation should not be counted against the contractor in performance measurement?

HHS staff cannot cancel an FFM or CSC. If a family cancels an FFM or CSC, the contractor will not be penalized. If HHS attempts to cancel an FFM or CSC, notify the HHS supervisor and follow the dispute resolution protocol.

Why can't the Parents' First Step Plan be included in the PRC notes that are due within three business days of the PRC? Requiring QA to upload a separate document into JARVIS creates an additional administrative step. Submitting PRC notes by the next business day would align with CSC documentation expectations, and facilitators are already accustomed to this process. This approach would also ensure that the Parents' First Step Plan is provided to families within 24 hours.

HHS will develop the First Steps Plan with the family. Development of this plan should occur during the PRC when the family is able to participate in the discussion. The

provider is not required to upload the First Steps Plan as this will be uploaded into the HHS File Manager by the HHS worker.

Post termination of parental rights FFM will this be done with the placement family? Will there be a referral or is this just expected?

Yes, a post-TPR FFM would occur with the placement family. As these FFMs would be on an as-needed basis, the HHS worker will send a separate referral email to the contractor.

Who is responsible for providing interpretation services during a PRC?

The provider agency is responsible for providing interpretation services. Given the intensity of PRCs and wanting to ensure parents understand what is expected of them during the case, we'd prefer that a professional (non-natural support) interpreter be used during the PRC. It is appropriate for an adult natural support to aid with interpretation if the provider is unable to find a professional on short notice. Discourage the use of minor children to interpret for their family unless no other options are available.

How should PRC Notes be uploaded into the Provider Portal?

PRC notes should be uploaded under family casework in the provider portal. Please use “CSC/FFM/YTDM/SPC Notes or Plan” as the document type and include the meeting date in the display name.

Does the Post Removal Conference replace Bridge Meetings?

If both the parents and the placement caregiver are present at the PRC, the PRC can serve as the bridge meeting for the case.

Is there an actual “referral” for PRCs?

A box will be added to the referral face sheet to indicate that a PRC is needed. In the meantime, the HHS worker should write “PRC” in the space next to “Agency Services-Family Casework”. Space will also be added to note the date and time of the PRC.

If services are already in place and a child is removed, what “refers” the PRC to the provider?

Update the referral face sheet to include PRC information and send to the provider. Include the removal order if available.

Will the FCS provider facilitating PRCs be trained to facilitate FFMs?

The PRC facilitator will receive training in facilitating PRCs, with specific emphasis on understanding the impact of removal on children and parents, general understanding of the HHS and judicial processes surrounding removal and out-of-home placement, and de-escalation skills. Many PRC facilitators will likely be trained to facilitate FFMs as well, though it is not a requirement that facilitators be trained in both types of meetings.

Are PRCs for foster care cases or all removals?

PRCs are for all cases where a court-ordered removal has occurred.

Is a PRC needed for a safety plan with the children out of the home or just court ordered removals?

PRCs are for all cases where a court-ordered removal has occurred.

Does the placement need to be present at the PRC?

No, the placement caregiver is not required to attend.

Does a foster parent have to be involved in the PRC if they wish not to?

No, foster parents are not required to participate in PRCs.

Do PRCs need to be in person?

The provider/facilitator, HHS worker(s), and family must be in person, all other attendees may attend virtually if they are not able to attend in person.

Who is responsible for scheduling the PRC?

The removing HHS worker is responsible for scheduling (this will typically be the CPW, but the HHS Case Manager is responsible for scheduling if they are the removing worker).

Can FCS count the PRC as a casework contact?

No, the PRC is not considered a casework contact.

Is there going to be a list of dates/times that PRCs are going to occur to provide for different areas of the state?

Each local office is expected to set their own schedule based on the frequency of removals in their area.

Will PRCs be occurring in the family's home or in the office?

PRCs will generally be in an office or other established location to ensure adequate private space is available.

If natural supports are identified prior to the PRC should they attend the meeting?

If the parents are comfortable with the natural support being present, they may attend. Note that it is not required for natural supports to attend.

For a family requested FFM who should this go through & how would the other party need to be notified?

The family should request an FFM through their HHS worker. The HHS worker then needs to send an email to the provider requesting that an FFM be scheduled. If the family requests through the provider instead of their HHS worker, the provider should send an email to the HHS worker and begin planning for the FFM.

Can an MCM count as an FFM if it occurs within those 30-day windows?

Yes, an MCM can count as an FFM if it occurs within the 30-day window before or after an FFM would otherwise be scheduled. The family, provider, and HHS worker must all be on the call and the discussion needs to include conversation about the parent's progress and next steps.

Does an FFM have to occur on the exact day that is 6 months after the previous meeting?

No. The first FFM occurs 60-90 days into a case and following FFMs should occur around every 6 months after. If the FFM occurs up to 30 days before or 30 days after the 6-month mark it is considered timely.

How should FCS providers handle a referral for FI after a removal, but a PRC referral was not included?

Request that the HHS worker update the referral to include a PRC.

For cases transitioning from the old contract to the new contract, how is the due date calculated for reports?

The due date for reports is based on the date of the original referral under the old contract. Example: Original 3055 was sent on April 10, due date for reports is the 10th of each month. Case transitioned to the new contract and the new 3055 was sent on July 1. Reports continue to be due the 10th of each month.

For the background checks that are being done for natural supports, is there a form that will be used statewide for consistency?

For natural supports, the HHS worker will review JARVIS history, Iowa Courts Online, and the Sex Offender Registry at a minimum. HHS workers should follow any additional requirements set by their Service Area.

08/14/2026 additions

Who is invited to the PRC?

The family, placement caregiver, provider who will supervise interactions (or their supervisor), HHS removing worker, and facilitator are required to attend. The family may choose to bring their own supports. A Parent Partner will contact the family prior to the PRC and offer to attend with the family. If known, the parents' attorneys and the GAL should be invited to attend (they may attend virtually if not able to attend in person), though their availability to attend should not delay the meeting occurring.

In the FAQ under FFM and PRC it talks about parents first step plan and that HHS develops this with the family. The provider thought that meant HHS does this when going to family to do removal. In the FAQ is says first step plan done by HHS at the PRC.

Can you clarify when (on a removal case) the first step plan is done?

The First Steps Plan should be completed at the PRC. The goal is for the full group to discuss together and provide support to the family in developing their plan. The HHS worker is expected to lead that part of the discussion since they're the ones with the case knowledge at that point and the provider/facilitator completes the form.

To ensure all docs are properly uploaded to the right place, could you let us know where the PRC notes should be placed within Jarvis?

The PRC notes should be uploaded under Family Casework. The provider can select "CSC/FFM/YTDM/SPC Notes or Plan" for the document type and include the meeting date in the Display Name.

If we remove from one parent & not the other would the expectation be that we hold a PRC?

Whether a PRC is needed when child is removed from one parent and placed with the other should be determined on a case-by-case basis. If the placement parent has not had an active role in the child's life, a PRC could be helpful to ensure critical information is shared as well as establishing an interaction plan and first steps plan. Even when a parent has been actively involved in the child's life, the PRC remains an opportunity to discuss family interaction planning, first steps planning, and gather child well-being information for the initial case plan.

When should Parent Partners be invited to PRCs?

Parent Partners should receive referrals for PRCs so they are able to offer support to the parents before and during the PRC. If there is an assigned Parent Partner, this should be noted in the referral. Complete the Parent Partner section of Form 470-5150, Referral Face Sheet, and send to the Parent Partner coordinator.

Are the Bridge meetings still going to occur? Or did PRCs take their place?

When the placement caregiver is able to attend, the PRC can count as the bridge meeting. Note that placement caregivers are not required to attend the PRC. If the placement caregiver does not attend the PRC, a bridge meeting will need to occur.

Should a PRC be held if the parent(s) do not attend?

We still want to hold a PRC, even if parents do not attend. The PRC is an opportunity for HHS and provider to share information, discuss expected case outcomes, and discuss engagement strategies for the family. If the placement caregiver is in attendance, it is also an opportunity to share information about the child. The placement caregiver may also have scheduled appointments for the child and can give information about dates and times.

While the Family Interaction Plan cannot be completed with the parents, it is still an opportunity to discuss sibling interactions (if needed) and keeping the child connected to their home and community (grandparent visits, sports/community activities, etc.).

Are we still holding an initial FFM when we are doing the warm hand off? Based on the trainings I observed there was no discussion of this being the initial FFM any longer.

No. The initial FFM format for warm handoffs is no longer required.

Non-Agency, Natural Supports and General

What is included in "concrete supports"?

Concrete supports means assistance in obtaining provisions such as clothing, food, furniture, and other items that address basic needs of the child(ren) and family.

How will HHS address situations in which the judicial system orders services outside the scope of the RFP? For example, judges in some service areas order Family Preservation services beyond the contracted timeframes, sometimes extending to multiple rounds or several months of service.

When the judicial system orders services outside the scope of the contract, a discussion should occur with the local HHS leadership for resolution. If services outside the scope of the contract are ordered on multiple occasions, the FCS provider may bring this to the attention of the Contract Manager for further evaluation.

Will the Agency consider revising or providing exceptions to the 3% cap on Concrete Supports, given that providers have limited control over expenditures such as court-ordered services or HHS-directed purchases? A fixed cap exposes providers to fiscal risk and may lead to noncompliance when mandated supports exceed 3%.

The 3% cap for contractors is intended to be the maximum amount contractors are expected to spend. If additional funds are needed, HHS will work with the family to identify other means of meeting the need. The intent of the 3% cap is to provide clarity between concrete support costs covered by the provider and concrete support costs covered by HHS. Court-Ordered Services funding is available for items or services that are specifically court ordered.

Will there be a grandfather phase or "exception" process for staff who have other education or experience?

FCS providers employed prior to 7/1/26 who do not meet education/experience requirements will be allowed to continue providing services.

What documentation does the natural support complete during interactions?

The natural support will complete Form 470-0304, Interactions Supervised by Natural Supports, after each interaction. The HHS worker is expected to meet with the natural support at least every other month to gather information about how visits are going and document this for the court. At those meetings, the HHS worker should collect the completed form and provide a new form to the natural support if needed.

Can you share any information you have about whether a provider can or shall do some work out of state if it's near the financial county?

Contract requirements for the FCS contract cannot be enforced outside the borders of Iowa. HHS cannot make work outside Iowa an expectation of the case, though it is permissible to ask the contractor if they would be willing. Keep in mind that this does not set a precedent for any other cases.

Do Crisis Response Plans take the place of Safety Plans?

No, Crisis Response Plans do not take the place of Safety Plans. The HHS Safety Plan looks at what has already gone wrong for the family and lays out what must happen to keep the child safe in the home. The Crisis Response Plan looks at what could go wrong for the family and lays out what the family can do to prevent that from happening as well as what the family can do to get through it if it happens.

The two documents can work together, with the Crisis Response Plan expanding on how the parents will keep the child safe. If the Safety Plan addresses substance use and that parents will not use, the Crisis Response Plan could focus on how the family will prevent the parents from using again (coping skills, community supports) and what they will do to keep the children safe if they do use (who to call, where the children will be, when the parents will know it is safe for the children to return home).

What specific document or tool will contractors use to identify natural supports?

The Social Network Map will continue to be used as the primary tool to identify natural supports.

Is the IS able to see the client on the same day as an FSS contact or family interaction? For example, can the IS provide SafeCare then have this session immediately followed by a family interaction? The joining of these services is beneficial for teaching and then practicing and is beneficial for service provision in rural areas.

Yes, services may occur consecutively on the same day, particularly if it is supporting teaching and practicing new skills, provided that they are different lines of service. The same service may not be provided in the same household more than once per day, e.g. two FMCW contacts may not occur in the same household on the same day. If two FMCW contacts occur in separate households (parent A's home and parent B's home) on the same day, this is acceptable.

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Are informal supports who are currently supervising interactions expected to go through the process of being "trained" as a Natural Support after July 1?

Natural supports who were approved to supervise interactions prior to July 1 are not required to complete the training. The HHS worker and their supervisor should discuss the natural support's strengths and challenges and determine on a case-by-case basis whether the natural support could benefit from the training (this only applies to natural supports approved prior to July 1).

Are 3055s changing?

There are no plans for immediate changes to 3055s. Continue to refer for services by entering services into FACS and creating the 3055.

If the natural support interactions are not with the provider, would HHS need to continue to talk with/meet with the natural support monthly or would it be on a less regular basis?

If there is not a referral for family interactions, the HHS worker and their supervisor have discretion to determine how frequently the HHS worker will meet with the natural support. It is expected that these meetings occur at least every other month.

Follow up to previous question- who will be responsible for getting the video & the agreement signed?

The provider is responsible for ensuring the natural support has watched the video and that the parents and natural support have signed the agreement. If no referral is made for family interactions, the HHS worker is responsible for completing these steps.

Will foster parents need to watch the video and sign the agreement?

No. Foster parents have completed training prior to licensing, which includes training on working with parents.

Will natural supports have to document interactions?

Natural supports are asked to keep a log of when interactions occur and who was present. Natural supports are not expected to provide any documentation of what happens during interactions. The purpose of the HHS worker's meetings with the natural support is to discuss what is happening during interactions and discuss any concerns the natural support has. The HHS worker is responsible for documenting these conversations and providing a summary in their reports to the court.

Does HHS need to document their visits/contacts for the monthly meetings with natural supports?

HHS workers should document visits/contacts with anyone involved with the case.

When opening Non-Agency Services/SafeCare for a family in two separate households in the Provider Portal, should Non-Agency documents be placed in the same service line?

Each household should have their own service line in the Portal.

Who is responsible for developing the First Steps Plan?

The HHS worker is responsible for facilitating the development of the First Steps Plan. The provider is responsible for documenting the plan while HHS leads the discussion.

Is the First Steps Plan required for Non-Agency cases?

No. The First Steps Plan is not required, though there may be cases where it could be helpful for the family.

Parent is not available, deceased, incarcerated, and child is in out-of-home placement. What is FCS' role?

When a parent is not able to be located/deceased, HHS should hold the FCS referral until contact has been established with the family.

When a parent is incarcerated, the HHS worker should evaluate whether it is beneficial for the parent to participate in Family Centered Services. If the parent will be released during the expected life of the case, the HHS worker should make a referral to FCS if the parent does not have access to similar services through jail programming and the facility will allow the provider to meet with the parent. If the incarcerated parent is serving a longer sentence and is unlikely to be released in time to have an active role in the child's life, the HHS worker should consult with their supervisor about requesting that the juvenile court not order that the incarcerated parent participate in FCS.

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Youth is in shelter and waiting for QRTP. Should FCS be involved?

No. A referral for FCS would not be appropriate as the child's next step is a higher level of care. If the youth has other siblings who remain in the home and the family could

benefit from services focused on the safety and well-being of the children who remain in the home, make an FCS referral.

Youth's permanency goal is APPLA. What is the role of FCS?

For APPLA youth, an FCS referral is appropriate to help stabilize placement or work with the youth on independent living skills.

Youth is in placement with a kin/fictive kin caregiver. Parents are not involved at all and have not been involved. What is FCS' role?

If the youth's permanency goal is reunification, the provider will make efforts to engage the parents in services and/or focus on placement stability depending on the goals identified in the referral.

If the youth's permanency goal is APPLA, goals should focus on placement stability and development of independent living skills.

No parents, youth is 17 in placement. FCS in the past has been focused on support of the child in placement. Child is not court ordered APPLA. What is FCS's role?

Continue to focus on supporting placement stability.

No court involvement, youth is kin/fictive kin care and has behaviors. Dad is involved. No interactions for FCS as dad has unlimited interactions with the youth. Mother's rights were previously terminated. FCS's role? Do we provide family casework to dad only?

Provide Family Casework to dad only. Referral should reflect that mother's rights were terminated.

For cases transitioning from the old contract to the new contract, how is the due date calculated for reports?

The due date for reports is based on the date of the original referral under the old contract. Example: Original 3055 was sent on April 10, due date for reports is the 10th of each month. Case transitioned to the new contract and the new 3055 was sent on July 1. Reports continue to be due the 10th of each month.

For the background checks that are being done for natural supports, is there a form that will be used statewide for consistency?

For natural supports, the HHS worker will review JARVIS history, Iowa Courts Online, and the Sex Offender Registry at a minimum. HHS workers should follow any additional requirements set by their Service Area.

Do all natural supports have to go through the training process? For instance, if we placed a child with a relative/fictive kin and they are willing to supervise interactions with the parents, do we explain the expectations with training to follow so child/parents can engage right away or do we need to pause natural supports supervising interactions until after they complete the training?

When a child is placed with a kinship caregiver and the kin caregiver is willing to supervise interactions, explain that the provider will follow up to schedule co-facilitation. Provide the caregiver with a link to the training video and discuss basic safety expectations with the natural support. Let the natural support know the provider will review the expectations in more detail at a later date.

Do we have to do both the Action Plan and the fridge sheet as they appear redundant?

Action Plans are not required in FMCW. The First Steps Plan and “fridge sheet” are the same thing. The First Steps Plan is intended to be something a family would “hang on their fridge” so they have easy access to information about the start of their case.

If a natural support has been supervising interactions but concerns develop after July 1, can we refer to FCS to go through the natural supports training?

Yes. The intent of the training is to provide support and guidance to the natural support. If the HHS worker believes the natural support would benefit from the training, update the referral face sheet and indicate in the referral email that the referral is for the natural support.

Are all the forms being completed now supposed to be uploaded to EDMS?

No. The First Steps Plan, Crisis Response Plan, and Natural Supports forms are not required to be uploaded to EDMS. Information from these documents should be incorporated into the Case Plan/court reports.

For Non-Agency cases after FCS closes: If Non-Agency decides the family would benefit from Safe Care, can or does HHS have to make a referral or can FCS provider decide and make the referral/decision? Typically, this happens after HHS has closed their case and referred to Non-Agency and the provider has had to reach out to the prior HHS worker to have a referral for Safe Care. Does this change now so the provider can make that determination?

If the provider believes that a Non-Agency SafeCare referral is needed for a case that is involved in Non-Agency Services, the provider should discuss this with their supervisor and send an email to the referring HHS worker letting them know the provider plans to open Non-Agency SafeCare.