IOWA
HHS

Foster Group Care Services (FGCS)
Qualified Residential Treatment Programs (QRTP)
Service Plan/Quarterly Progress Report/Discharge Summary Report Instructions

The Service Plan/Quarterly Progress Report/Discharge Summary is used throughout the episode of service to report the initial service plan and any updates, quarterly progress (also used to report progress in addition to quarterly), and the discharge summary. The Service Plan shall be updated monthly, at minimum. The Quarterly Progress Report should include detail regarding monthly Follow-Up Planning Conference information. Additional service plan updates shall be completed upon receipt of a new Case Permanency Plan/Juvenile Court Services Plan or as otherwise needed to address the changing needs of the Child. The Discharge Summary information shall be completed upon the Child's discharge. QRTP.

The Service Plan and related progress shall document collaboration with the Referral Worker, Child and Child's Family or guardian (unless a reason for noninvolvement is documented in the case record), the Child's Positive Support System, and any other key individuals as identified.

- At the top left of the document, enter an "X" in the box to identify the report being completed– this is done by hovering the mouse pointer over the box and clicking.
- The Service Plan shall be completed and provided to the Referring Worker and the Parent(s) or guardian within fifteen (15) Business Days of the date of admission.
    - In addition, the Service Plan must be reviewed with the Child and Parent(s) or guardian within fifteen (15) Business Days of the date of admission.
- The first Quarterly Progress Report shall be completed no later than 90 days following the date of admission, and at least every 90 days thereafter throughout the episode of service. Progress or changes may be reported more frequently as needed. In addition, Service Plan updates shall be completed upon receipt of a new Case Permanency Plan/Juvenile Court Services Plan and as needed to address the changing needs of the Child.
    - A copy of each required Quarterly Progress Report must be provided to the Referring Worker, Parent(s) or guardian, and reviewed with the Child and Parent(s) within five (5) Business Days of the report due date.
    - Other updates (receipt of a new Case Permanency Plan/Juvenile Court Services Plan or to address the changing needs of the Child) shall be provided to the Referring Worker, Parent(s) or guardian, and reviewed with the Child and Parent(s) within five (5) Business Days of the completion date of the report.
- The Discharge Summary information of this report shall be completed and provided to the Referring Worker, Parent(s), or guardian within ten (10) Business Days of the Child's discharge date.
    - Post-discharge plans for each child shall be discussed with the Child prior to discharge.

All reports must be provided to the Referring Worker using: 1) the HHS Provider Portal for Contractors for HHS cases; or, 2) secure and confidential email to the JCS worker for JCS cases.

Case Information – Complete All Fields

- Child's Name.
- Date of Birth.
- Names of Child's Family/Kin and their address/phone information.
- Referral Date – date the referral was received.
- Admission Date.
- State ID.
- County Name and Number – Name and number of County of Financial Responsibility (e.g., Black Hawk 07).
- HHS Service Area – Service Area of the County of Financial Responsibility.
- HHS/JCS Referring Worker – Name, HHS or JCS, phone number and email address.
- Discharge Date – record N/A when completing the report for Service Plan or Quarterly Progress Report. Record the Child's discharge date when completing the report information for discharge purposes.
- Service Plan Date – date the Service Plan was completed. This date will not change.
- SP/QPR Date – date the Service Plan update/Quarterly Progress Report (or additional reporting) was completed. This date will change as SP/QPR updates are done. When completing the Discharge Summary information, the latest SP/date used will remain.
- Next Report Due Date – date the next SP/QPR is due (no more than 90 days from the last). Note that the SP/QPRs may be updated prior to the Next SP/QPR Due Date. Reporting should be completed at the time of this update and then a due date for the next report should be identified based on that latest plan update. Record N/A when completing the Discharge Summary information.
- Discharge Summary Date – date the Discharge Summary information was completed.
- Date Report provided to HHS/JCS Referring Worker.
- Date Report provided to Parent(s) or Guardian.
- Date Report reviewed with the Child – date the Caseworker reviewed/discussed the report with the Child.
- Date Report reviewed with the Parent(s) or Guardian – date the Caseworker reviewed/discussed the report with the Parent(s) or Guardian.
- Caseworker – Name of assigned Caseworker, direct phone number, and email address.
- Education Specialist – Name of assigned Education Specialist, direct phone number, and email address.

Report Components

All information entered must be dated and remain in chronological order throughout the episode of service, beginning with the initial Service Plan and followed by Service Plan updates and Quarterly Progress Reports leading to the Discharge Summary. Enter N/A in each Service Plan component's Summary at Discharge area until that information is completed.

Each report component with ***general*** guidance is listed below. References to the contract sections related to the report components are included and these ***shall be used*** by the Contractor to ensure a comprehensive completion of the report. Service provision must be individualized and Child specific.

Service Planning Conference Component - Reference Contract 1.3.4.2.3 ii.

"*Service Planning Conference*" *means a meeting conducted by the Contractor with the Referral Worker, the Child and the Child's Family, and other key individuals after admission as a means of developing the core components of the Service Plan including, but not limited to, Family and community connections, physical and mental health, education, and Reintegration Planning.*

- The Service Planning Conference shall be conducted within five (5) Business Days of the Child's admission date.
- Include the date of the Service Planning Conference, identify all who were present, and describe the relationship of the participants to the Child.
- This initial information will not change throughout the episode of service.

Follow-Up Planning Conference

- The Follow-Up Planning Conference shall be completed at least monthly.
- For each Follow-Up Planning Conference, include the date, identify all who were present, describe the relationship of the participants to the child, and provide a brief overview of the meeting.

  *Additional planning notes will be added throughout the episode of service. If subsequent service planning results in changes to the Service Plan, update each Service Plan Component as needed and send the update to all parties.

Service Plan Goals Component

"Service Plan" *means the plan developed by the Contractor in consultation with the Child and the Child's Family (unless a reason for noninvolvement is documented in the case record), the Referral Worker, and significant others, whenever appropriate. This is the "care plan" required in Foster Group Care, Emergency Juvenile Shelter, and Supervised Apartment Living. The Service Plan shall be based on individual Child assessment as required by licensure and include the following: (1) Identification of specific needs; a description of all planned services and goals and objectives with projected dates of accomplishment intended to meet the specific needs of the Child; (2) Action steps to be taken by the Child, the Child's support system, and staff and the frequency of actions or services; where services will occur; and, the Caseworker who will be responsible for the Service Plan. The Service Plan shall include the Child-specific Crisis Intervention and Stabilization and Reintegration Plans and be coordinated with other service plans (e.g., Family Interaction, Behavioral Health Intervention Services or other mental or behavioral health services) and assure continuity of the Child's day to day life activities while in care, such as, but not limited to, school, Family relationships, health care, mental health and behavioral needs, etc.*

Goals shall be individualized and based on each Child's unique needs. Additional Goals may be added throughout the episode of service.

- Objectives – should be written in observable and measurable behavioral terms to allow progress monitoring.
- Projected Completion Date – insert the date identified when completing the Service Plan. This date may change according to Service Plan updates/QPR updates.
- Completion Date – insert the date the Objective was completed.

- Action Steps – identify the steps to be taken by the Child, the Child's support system, and staff, the frequency of actions or services, and where services will occur. Updates and/or changes may occur throughout the episode of service.
- Person(s) Responsible – identify the person or persons responsible for each action step (Child, member of Child's support system, staff, etc.)
- Progress - describe progress made during the reporting period. Include barriers to progress, if any, and response to address barriers. Include specifics regarding utilization of specialized assessments (PSB, NACC, SJDP). Identify and explain any changes and/or updates to the Actions Steps
- Outcome – describe the final result of actions taken or summarize the status of each objective at the time of discharge.

Individual Child Development and Life Skills Component – Reference Contract Section 1.3.4.4
Casey Life Skills Assessment

- This is the date of the completed assessment and summary of results.

Reassessments

- This is the date of each reassessment and summary of results. Each Child shall be reassessed, at minimum, within 30 days of the Child's 14th, 16th, and 18th birthdays and prior to discharge or hand-off to another Contractor. Assessments shall be done as needed to address the changing needs of the Child.
- Life Skills Plan
- Must be child-driven, targeted, and effective life skills services to develop skills identified through the assessment to ensure the Child's ability to return to the community or the Child's Family.
- Identify life skills training curriculum and facilitation.
- Progress During Reporting Period and Changes to Plan
- Summarize child development and life skills activity and progress during the reporting period.
- Include the Child's and Family's response to the provision of service.
- Identify changes to the plan and reason for changes.

Family and Community Connection Component – Reference Contract Section 1.3.4.5
Family and Community Connections Plan

- Describe the child-specific plan that will be used for the Child to maintain relationships with the Child's Family and Positive Support System.
- Describe how required contacts with Parent(s) and siblings will be facilitated. Include specifics such as when, where, and how often these will occur.
- Describe activities coordinated with a Family Interaction Plan (if applicable).
- Describe Family Identification efforts to be undertaken and by whom these will be completed

Summarize Family and Community Connections During Reporting Period

- Include the Child's and Family's response to provision of service.
- Identify changes to the plan and reason for changes.
- Describe contacts which took place (visits, family therapy sessions, etc.).

Crisis Intervention and Stabilization Plan Component - Reference Contract Section 1.3.4.6
Individualized Crisis Intervention and Stabilization Plan

- These shall be individualized to each Child's unique needs.
- Include appropriate behavior management and de-escalation techniques that will be used to address situations that may lead to Critical Incidents. Describe multiple methods of communication that will be used to notify the Child's Parent(s) or guardian and Referral Worker personally and immediately regarding any death while in care, serious illness, incident involving serious bodily injury, or circumstances causing removal of the Child from the facility.
- Include intervention and stabilization methods that will be used when the Child is in the home (home visits) or other community setting.
- Describe how the Family and/or Positive Support System will be educated regarding the plan.

Crisis Interventions During Reporting Period and Changes to Plan

- Summarize crisis interventions used and the Child's response to their individualized plan during the reporting period.
- Identify changes to the plan and reason for changes.

Reintegration Planning Component – Reference Contract Section 1.3.4.7
"Reintegration Planning" *means a component of the Child's Service Plan developed by the Contractor together with the Child, the Child's Referral Worker, and the Child's Family after admission to initiate thinking about exit and discharge to assure a successful move home or to the next living arrangement and to assure the continuity of Clinical and support services. Reintegration Planning begins no later than the Child's Service Planning Conference.*

Reintegration Plan

- Reintegration planning shall be initiated at the time of the Service Planning Conference to begin thinking about exit and discharge to ensure a successful move home or to the next living arrangement. Identify the anticipated setting where the child will go upon discharge.
- Address individual services/activities needed while the Child is in care to achieve the placement goal and ensure successful transition.
- Define the plan for the facilitation of Family visits and how skills the child is learning will be included in the family visit and will be assessed upon return back to the facility.
- Describe how the continuity of the Child's day-to-day life activities (e.g., but not limited to, treatment services, school) identified as being in the best interest of the Child will be maintained.
- If the Child discharges to their Family or other Family-like setting, include plan for post-discharge face-to-face contact and interactions to ensure the Child is effectively reintegrating for a minimum of one month.
- Identify connection/linkages that will take place in preparation for and during the six-months of post-discharge services.

Progress During Reporting Period and Changes to Plan

- Summarize reintegration activity and the Child's and Family's response during the reporting period.
- Identify changes to the plan and reason for changes.

Education Component – Reference Contract Section 1.3.4.8
Education Plan

- Summarize each child's present educational status, such as, but not necessarily limited to, grade level, current school attending, and any special education needs/recommendations.
- Identify where the Child will attend school.
  - Define the plan to continue with the curriculum and progress of the child's school of origin and describe a transportation plan (if needed).
  - If a child will not remain in their school of origin, explain reason why it is not in the Child's academic, emotional, or social best interest to travel to the school of origin and who was involved in making the decision.
- Coordination of needs and services.
  - Address special education recommendations.
  - Address supplemental educational support such as tutoring and school-based conferences.

Progress During Reporting Period and Changes to Plan

- Summarize the Child's educational progress, identification of needs or supports, and any educational or vocational testing done during the reporting period.
- Include the Child's response to the Education Plan.
- Identify changes to the plan and reason for changes.

Physical Health Component – Reference Contract Section 1.3.4.9
Physical Health Summary and Identified Needs or Supports (medical, dental, vision)

- Report standard health information including, but not limited to, the Child's last physical exam, primary care physician information, current medications, allergies, and vision and dental information.
- Identify sufficient health services and supports needed to improve the Child's overall well-being.
- Include plans to ensure continuity of care, coordinating the health care received prior to placement with the health care provided or needed while in care and post-discharge, respectively.
- Plan for 24-hour emergency medical and dental health care including the communication of emergency health care to the Child's Family or guardian and Referring Worker.
- Include other areas described in the contract as needed.

Supports Provided and Newly Identified Needs During Reporting Period

- Summarize services (including emergency care, if any) and supports provided during the reporting period.
- Include the Child's and Family's response to services and supports.

- Include identification of additional health care needs and the services and supports provided or needed to address the Child's well-being.

Mental and Behavioral Health and Clinical Support Component - Reference Contract Section 1.3.4.10

Mental and Behavioral Health Summary and Identified Needs and Clinical Support

- Detail each Child's present mental and behavioral health services.
- Incorporate short-term and long-term mental and behavioral health goals of youth from the Admission Clinical Review Form.
- Include an individualized plan to ensure continuity of care during and post-discharge.
- Identify needs and clinical support and describe a plan for coordination of these services.
- Describe how communication and education of the Child and Family regarding mental/behavioral health treatment, including how the Child will be monitored.
- Include substance abuse evaluation results as needed and describe how resultant services will be coordinated with mental/behavioral health services.

Supports Provided and Newly Identified Needs During Reporting Period

- Summarize services and supports provided during the reporting period.
- Include the Child's and Family's response to services and supports.
- Include identification of additional mental and behavioral health needs and the services and supports provided or needed to address the Child's well-being.

Medication Management Component – Reference Contract Section 1.3.4.10 (l).

- Detail current medication(s) and dosage(s).
- Update this section as needed regarding the individual's medication management plan beyond simply ensuring proper administration of medications. For example, but not limited to, observations of medication effects on each child, the child's reaction to use, side effects, and how this information is communicated to the Child's Parent(s) or guardian and the Referring Worker.
- Include how the Child and Family will be educated regarding medication management.

Changes in Medication and Observation of the Child's response to medication during reporting period

- Summarize the Child's response.
- Include concerns the Child or Family may have regarding the medication.
- Detail changes in medication and/or dosage.

Completing Discharge Summary Information

Discharge Summary information will be completed for each report component in the designated "Summary at Discharge" area as well as the Discharge Information at the end of the report. The final Service Plan/Progress Report/Discharge Summary report will be completed and provided to the Referring Worker, Parent(s), or guardian within ten (10) Business Days of the Child's discharge date.

Ensure each report component of the Service Plan contains the latest information from the date the Service Plan was initiated, through progress reports, and through the Child's discharge date.

When completing the Summary at Discharge for each report component, include conclusions regarding the effectiveness and outcomes of each.

Discharge Information

- Admission – Admission date will populate from entry on page 1.
- Discharge – Discharge date will populate from entry on page 1.
- Number of Days in Care – Enter total number of days in care.
- Discharge Setting - Identify by name the setting to where the Child was discharged.
- Reason for Discharge - Describe the reason for discharge.
- Medications - Identify the prescribed medication(s) at discharge and plan for continued medication management.
- Family or Family-Like Setting – Enter an "X" in the box indicating yes or no.If yes, include the plan for face-to-face contact and interactions for at least one month post-discharge to ensure the Child is effectively reintegrating.
- Post Discharge Plan: Include the plan for post discharge services.
- Service Effect: Describe the overall effect of the services provided toward accomplishing the identified goal(s) and outcome(s). Identify individual Child Development and Life Skills accomplishment.

Signatures

- Signatures of the Caseworker and Caseworker Supervisor are required upon submission to the Referring Worker.