DPHHS - CFSD FACILITY PROFILE

REF. DOC.
CFS 402-A
Rev. 10/2020

FOR CFSD USE ONLY:
DATE SUBMITTED: ______________
CONTRACT #: ________________

This Department of Public Health and Human Services (DPHHS) form can serve any one of three different purposes:

1. To make an initial classification application for placement on the DPHHS Foster Care Rate Matrix.
2. To request a reclassification on the DPHHS Foster Care Rate Matrix due to specific program changes.
3. To update DPHHS when a facility makes any program changes to the services provided. This information may be used to revise childcare directories, ensure appropriate referrals, and share program information.

IMPORTANT NOTES AND INSTRUCTIONS:

A. The Administrative Rules of Montana (ARM) for a DPHHS license provide the minimum requirements necessary to operate a specific type of facility. The ARM for the DPHHS Foster Care Rate Matrix and Classification System provide the criteria to determine the daily rate of payment for a licensed facility.
Statutes and Rules that apply to Youth Care Facilities:
Montana Code Annotated: 41-3-201 through 41-3-203, Mandatory Report of Child Abuse and/or Neglect, 52-2-Part 6 Youth Residential Services
Administrative Rules of Montana: ARM 37.97.101 through 37-97.191 – General Requirements, 37.97.201 through 37.97.270 - Child Care Agencies, 37.97.903 through 37.97.907 - Therapeutic Group Homes, 37.37.301 through 37.37.336 - Therapeutic Family Care, 37.37.315 through 37.37.320 – Classification, 37.97.501 through 37.97.528 – Youth Group Homes, and 37.97.801 through 37.97.843 – Youth Shelter Care

B. To obtain a foster care services contract with DPHHS, you must complete and submit this Facility Profile (FP) **and**:
1. Maintain a current DPHHS License per ARM 37.97.105;
2. For initial classification or reclassification, obtain written approval from the local DPHHS Regional Administrator, stating the need for these services in the community; and
3. Receive a Foster Care Rate Matrix Classification of your facility.

C. **READ THE FACILITY PROFILE GUIDELINES BEFORE COMPLETING THIS PROFILE.**
The **Facility Profile Guidelines** have been provided as a tool for further detail (descriptions, explanations, and definitions) regarding specific items within this form.

D. This document will become an attachment to the foster care contract, if accepted by DPHHS.

E. **One** Facility Profile may be used for multiple facilities as long as the facilities are reimbursed at the same daily rate and the facilities use **EXACTLY** the same policies and procedures.

F. Obtaining a DPHHS license does not guarantee a DPHHS contract.

G. Obtaining a DPHHS foster care contract does not guarantee placements by DPHHS.

If you have any questions about completing this form,
please contact CFSD Contracts Coordinator at CFSDContracts@mt.gov or 406-841-2431.

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Check **ONLY ONE** box below to identify the reason this profile is being submitted to DPHHS:

1. ☐ Initial classification application
2. ☐ Reclassification request
3. ☐ Required update of program description if changes to the services provided are made

If more than one location is covered in this profile, please include the information for EACH location.

(For TFOC/CPA provide the following information for each main and satellite office of the program.)

NAME OF PERSON COMPLETING FORM:

PHONE/FAX OF PERSON COMPLETING FORM:

FACILITY NAME:

FACILITY ADDRESS: PHONE/FAX:

FACILITY DIRECTOR: PHONE/FAX:

NAME OF CORPORATION (IF DIFFERENT FROM FACILITY NAME):

CORPORATION ADDRESS (IF DIFFERENT FROM FACILITY): PHONE/FAX:

NAME OF EXECUTIVE DIRECTOR (IF DIFFERENT THAN FACILITY DIR.): PHONE/FAX:

CONTACT FOR REFERRALS: PHONE/FAX/E-MAIL FOR REFERRALS:

WEBSITE ADDRESS:

SECTION 1: PLEASE INCLUDE:

1. ☐ CURRENT LIST OF BOARD OF DIRECTORS
2. ☐ ADDRESS AND FLOOR PLAN FOR EACH LOCATION (please label each floor plan with name and address of facility, room size, and function of each room) (N/A for TFOC/CPA)
3. ☐ ELECTRONIC COPY OF PROVIDERS COMPLETE POLICY AND PROCEDURE MANUAL

   (If referencing Policy and Procedure manual please be sure wording in manual accurately reflects ARM/MCA)

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SECTION 2: **TYPE OF PROGRAM/FACILITY: (choose ONE)**

1☐ Therapeutic Youth Group Home
- ☐ Campus
- ☐ Community

2☐ Therapeutic Family Foster Care/Child Placing Agency

3☐ Maternity Home/Child Care Agency

4☐ Youth Group Home

5☐ Youth Shelter Care

6☐ Youth Group Home/Shelter Care

SECTION 3: **TARGET POPULATION TO BE SERVED**

A. Age range of children this facility is licensed by QAD to serve:

A.1 Youngest age accepted: ______

A.2 Oldest age accepted: ______

B. QAD Licensed capacity: Male: ______ Female: ______ Total: ______

or the number of Therapeutic Family Foster homes currently licensed, supervised, and supported by each office ______

C. Average Length of Stay for Youth at the Facility: ________(N/A for TFOC/CPA)

D. Please specify the minimum IQ that the program will serve: ______

When a written description or further information is requested:

- Include the requested information, OR
- Indicate the **EXACT location** in the provided copy of your policy and procedure manual where the requested information can be found. Language in P&P Manual must accurately reflect ARM.

CFSD recognizes that Facilities have limitations with regards to the ability to serve particular populations of children, which often revolves around the severity of child's issues or behaviors. The remainder of Section 3 will address these limitations.

E. Place a check in the box before each item which identifies the following issues/behaviors/characteristics of youth to whom **you can provide** necessary services. **Leave blank those you cannot serve.**

E.1 ☐ Fetal Alcohol Syndrome (FAS)

E.2 ☐ Medical condition or physical disability - Identify any condition which is diagnosed or treated through medical or adaptive means that requires treatment or accommodations which the facility/program could provide. Examples could be seizure disorders, incontinence, rashes, sexually transmitted diseases, communicable diseases, diabetes, asthma, accessibility issues, etc. Use the text field to explain or reference EXACT location in Policy and Procedure Manual.

______

E.3 ☐ Pregnancy (latest trimester acceptable ______

E.4 ☐ Teen Parent and Child

E.5 ☐ Runaway:

E.5.1 ☐ Isolated incident(s) of runaway behavior

E.5.2 ☐ Chronic runaway history

If any item on E.5 is marked, further explanation is required. Use the text field to explain or reference EXACT location in Policy and Procedure Manual. ______

E.6 ☐ Physical aggression issues:

E.6.1 ☐ History of destruction of property

E.6.2 ☐ History of verbal assault or threats

E.6.3 ☐ History of assault toward animals

E.6.4 ☐ History of assault toward persons

E.6.5 ☐ History of homicidal ideation

E.6.6 ☐ History of homicidal acts

If any item on E.6 is marked, further explanation is required. Use the text field to explain or reference EXACT location in Policy and Procedure Manual. ______

E.7 ☐ Problematic Sexualized Behaviors: (Child who has been sexually abused and is actively exploring his/her sexuality either alone or with others. The child is not labeled a “sexual offender.”)

If E.7 is marked, further explanation is required. Use the text field to explain or reference EXACT location in Policy and Procedure Manual. ______

E.8. ☐ Sexual offender issues:

E.8.1 ☐ Incomplete evaluation status

E.8.2 ☐ No sex offender treatment history

E.8.3 ☐ Currently in sex offender treatment

E.8.4 ☐ Completed sex offender treatment
E.8.5 ☐ Incomplete sex offender treatment
E.8.6 ☐ Unsuccessful discharge from treatment

If any item on E.8 is marked, further explanation is required. Use the text field to explain or reference EXACT location in Policy and Procedure Manual. ______

E.9 ☐ Substance use, abuse, or dependency:

E.9.1 ☐ History of use (intoxication or getting high), not evaluated
E.9.2 ☐ Identified as needing outpatient treatment
E.9.3 ☐ Identified as needing inpatient treatment
E.9.4 ☐ Completed treatment
E.9.5 ☐ Incomplete treatment
E.9.6 ☐ Unsuccessful discharge from treatment

If any item on E.9 is marked, further explanation is required. Use the text field to explain or reference EXACT location in Policy and Procedure Manual. ______

E.10 ☐ Suicidal:

E.10.1 ☐ History of suicidal ideation - no attempts
E.10.2 ☐ Past attempt(s) - more than one year ago
E.10.3 ☐ Recent attempt(s) - within the last year
E.10.4 ☐ History of self-abuse/self-mutilation

If any item on E.10 is marked, further explanation is required. Use the text field to explain or reference EXACT location in Policy and Procedure Manual. ______

E.11 ☐ Fire setting:

E.11.1 ☐ Act that was not committed for purpose of causing harm or property damage
E.11.2 ☐ Deliberate act to cause harm or property damage

If any item on E.11 is marked, further explanation is required. Use the text field to explain or reference EXACT location in Policy and Procedure Manual. ______

E.12 ☐ Court status:

E.12.1 ☐ Adjudicated Youth in Need of Care
E.12.2 ☐ Adjudicated Youth in Need of Intervention
E.12.3 ☐ Delinquent Youth
E.12.4 ☐ Criminally Convicted Youth
E.12.5 ☐ Other (Parental Agreements, Consent Decrees, Emergency Placements) ______

E.13 Does the facility accept children placed privately by parents? ☐Yes; ☐No
If Yes, are admission requirements different for private referrals? ☐Yes; ☐No
If yes, **further explanation is required.** Use the text field to explain or reference EXACT location in Policy and Procedure Manual. ______

E.14 Does the facility accept children placed from out-of-state? ☐Yes; ☐No
If Yes, are admission requirements different for out-of-state referrals? ☐Yes; ☐No
If yes, **further explanation is required.** Use the text field to explain or reference EXACT location in Policy and Procedure Manual. ______
Note: Placements made by parents or agencies from out-of-state must be made in compliance with the state and federal laws for Interstate Compact on the Placement of Children (see Montana Code Annotated [41-4-101] et. seq. and Montana Administrative Rule 37.50.901)

E.15 Does the facility serve any other youth as a result of the program's provision of services through another program/grant (e.g. Runaway Act) that would be different than listed previously? ☐Yes; ☐No
If yes, **further explanation is required.** Use the text field to explain or reference EXACT location in Policy and Procedure Manual. ______

SECTION 4: CHARACTERISTICS OF FACILITY PROGRAMS, SERVICES AND RESOURCES

A. **Treatment philosophy and services:** Provide a brief description of the program offered, number and types of individual and group therapy offered, etc. **Include any information that distinguishes your program from other facilities.** Use the text field to describe or reference EXACT location in Policy and Procedure Manual. ______

B. **Staff training:** Description of any staff training specific to your target population or philosophy that is provided or required **in addition to** the training required by ARM/MCA. Use the text field to describe or reference EXACT location in Policy and Procedure Manual. ______

C. **Religious/Cultural needs:** Describe how this program is responsive toward both (a) religious and (b) cultural practices of youth placed in this facility's care. Specify those activities in which youth attendance is mandatory. Please note that under a contract with the Department, the Facility may not require church attendance or involvement in any particular religious activity. Use the text field to describe or reference EXACT location in Policy and Procedure Manual. ______

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D. **House Rules:** (N/A for TFOC/CPA) House Rules youth are responsible for following on a daily basis. Use the text field to describe or reference EXACT location in Policy and Procedure Manual. ______

E. Additional Programming: (N/A for TFOC/CPA)

1) If the facility provides an **Onsite School or Day Treatment** program, describe admission criteria, program location and staff credentials. Use the text field to describe or reference EXACT location in Policy and Procedure Manual. ______

   1.A Describe any **additional academic supportive services** (tutoring, etc.) provided by the program (not including onsite school or day treatment). Use the text field to describe or reference EXACT location in Policy and Procedure Manual. ______

2) Describe any **unique physical and non-physical recreational resources** utilized by the facility, the frequency of use, and how they are funded. Also detail circumstances when/if youth are excluded from participating in these activities. Use the text field to describe or reference EXACT location in Policy and Procedure Manual. ______

3) Summarize the facility's **summer/holiday program** plans for youth specific to your target population or philosophy, noting how it differs from the regular program during the academic school year (e.g., physical and non-physical recreation, daily routine). Use the text field to describe or reference EXACT location in Policy and Procedure Manual. ______

4) **Independent Living Programing:** Describe any program activities, **IF OFFERED**, to youth 16 and older to develop age appropriate independent living skills appropriate to the youth's abilities and permanency plan. (This does not include services offered through the CFSD Independent Living Program). Use the text field to describe or reference EXACT location in Policy and Procedure Manual. ______

5) **Follow up services after discharge:** Describe your aftercare services and/or coordination of aftercare services. Use the text field to describe or reference EXACT location in Policy and Procedure Manual. _____

SECTION 5: ADDITIONAL COMMENTS AND EXPLANATIONS - THERAPEUTIC YOUTH GROUP HOME AND THERAPEUTIC FAMILY CARE:

______

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CLASSIFICATION OF GROUP HOME, SHELTER CARE, DUAL LICENSED AND MATERNITY HOME ONLY

SECTION 6: CHARACTERISTICS OF FACILITY'S SUPERVISION AND SUPPORTIVE SERVICES:

Supervision Level:

Check one box that best describes your facility's Staffing Pattern for Supervision. Provide whatever explanatory comments are necessary for an adequate description (LEVELS IV, V, and VII reflect requirements for every 8 beds). If the facility is currently classified and employs more staff than required on their classification, please indicate any "extra" staff under Comments.

☐ Supervision Level IV: 24 hr. awake direct care staff (4.2 FTE) i.e., three 8 hr. shifts with a minimum of 1 person per shift; also includes .5 FTE program management and .25 FTE administrative support.

☐ Supervision Level V: 24 hr. awake direct care staff with additional day staff (7.0 FTE), i.e., three 8 hr. shifts with a minimum of 2 staff persons per day shift; also includes 1.5 FTE program management, .25 FTE program manager (director) and 1.0 FTE administrative support.

☐ Supervision Level VII: Child Care Agency-Maternity Home. 24 hr. awake direct care staff with additional day shift staff (7.0 FTE), i.e., three 8 hr. shifts with a minimum of 2 staff persons per day shift; also includes 1.5 FTE program management, .25 FTE program manager (director), 1.0 FTE administrative support, and 1.0 Bachelor's Level Social Worker.

Comments (Please list other staffing patterns for supervision that increases staff coverage beyond the facility classification listed above):

Supportive Services Level:

☐ Supportive Services Level I: 1.0 FTE Bachelors Level Social Worker to provide individual and group counseling supportive services.

☐ Supportive Services Level II-Group Home: 2.8 FTE Bachelor's Level Social Worker to provide individual and group counseling supportive services.

☐ Supportive Services Level III (May only be combined with Supervision Level V): 8.0 FTE Bachelor Level Direct Care Staff replace the direct care staff indicated by Supervision Level V (1.0 FTE must be dedicated to the provision of Supportive Services), plus 1.0 FTE Master Level human services professional, 0.25 FTE Licensed Mental Health professional. This level provides individual, group, and family counseling supportive services with clinical oversight. Comments: _____

SECTION 7: 'SUPERVISION/SUPPORTIVE SERVICES LEVEL CLASSIFICATION' (GH, SH, GH/SH and MAT) ONLY CHARACTERISTICS OF THE FACILITY'S STAFFING AND OTHER AVAILABLE RESOURCE PERSONS

A. List all position titles for paid and non-paid staff (volunteers and interns), minimum qualifications, the number of FTEs within each position, and the total number of person(s) who make up the FTE(s). **Include the Facility Director and differentiate this person from the Executive Director if appropriate.**

Position Title	Paid=P or Non-Paid=N	Minimum qualifications required in job description	Total # of FTEs in this position	Total # of persons in this position
A.1				
A.2				
A.3				
A.4				
A.5				
A.6				
A.7				
A.8				
A.9				
A.10				
A.11				

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TOTAL PAID EMPLOYEES	TOTALS COLUMN		
TOTAL NON-PAID STAFF	TOTAL NUMBER OF UNDUPLICATED PERSONS		

NOTE: In order for Volunteers or Interns to be counted toward the FTE requirements of the contract, the Volunteer or Intern must meet all qualifications of the position, be approved through the full background check process, complete all training required for that position, and when interacting with youth the Volunteer or Intern must always be supervised by a paid staff person who is qualified to provide that service (e.g., a direct care volunteer/intern would need to be supervised by a paid direct care staff person).

B. List any agencies and/or individuals, not employed by the facility who provide direct care and/or other services to youths in placement with effective dates of those services. These services are arranged through facility subcontracts, written agreements or other means, and can be in addition to those provided under the DPHHS/Facility Contract (the FP is Attachment B of the contract). Provide the name of the agency/individual providers, the services provided, amount of services provided (hours/week), and whether this is arranged by a subcontract or written agreement.

_____

SECTION 8: ADDITIONAL COMMENTS AND EXPLANATIONS: _____

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