MEDICAL FOSTER CARE STATEWIDE OPERATIONAL PLAN

April 2014

Coordination of Effort Among:

DEPARTMENT OF HEALTH
Children's Medical Services Network

DEPARTMENT OF CHILDREN AND FAMILIES
Community Based Care Program

and

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid Program

Copies of this document may be obtained through the Division of Children's Medical Services Central Office, (mailing address) 4052 Bald Cypress Way, Bin A06, Tallahassee, Florida 32399-1707, (850) 245-4200 as needed.

This Statewide Operational Plan is a coordinated effort between the Department of Health, Children's Medical Services; the Department of Children and Families, Protective Investigations and Community Based Care Program; and the Agency for Health Care Administration, Medicaid Program. This document has been reviewed and approved by staff from: Medicaid Program Development, Department of Children and Families Services Headquarters, and Department of Health, Children's Medical Services Central Office.

This Statewide Operational Plan is to be distributed by CMS Central Office to designated liaisons at the Department of Children and Families Headquarters Office, the Agency for Health Care Administration, Medicaid Program Headquarters Office and to each CMS Area Office and contracted MFC Area Office.

This Statewide Operational Plan is to be distributed by the MFC Supervisor or designee in each Area Office to local partners at the Department of Children and Families, Community Based Care Agencies, to include Protective Investigations, Foster Care Licensing and Foster Child Case Management and to the local Area Medicaid Office.

TABLE OF CONTENTS

ATTACHMENTS

Chapter 1 INTRODUCTION

Medical Foster Care Program Definition

Florida's Medical Foster Care (MFC) Program is a coordinated effort between the Agency for Healthcare Administration, (AHCA), Medicaid Program, the Department of Health (DOH), Division of Children's Medical Services Programs, and the Department of Children and Families (DCF), Child Protective Investigations and Community-Based Care lead agencies. The MFC Program, in collaboration with the Community-Based Care lead agencies (CBCs) recruits, selects, trains and oversees MFC parents, who then care for medically complex and medically fragile children under the age of 21 who cannot safely receive care with their family of origin, and are placed into MFC. MFC parents then perform most of the day-to-day therapeutic care for the MFC children.

Medical Foster Care Objectives

- Provide a family-based, individualized, therapeutic milieu of licensed medical foster homes for MFC children.
- Reduce the high cost of medical treatment associated with MFC children by eliminating the need for long-term institutional care;
- Enhance the quality of life and allow MFC children to receive home-based services specific to their medical needs that will enable children to develop to their fullest potential, regardless of their prognosis;
- Return MFC children to a safe home with their family of origin, if and when possible;
- Facilitate the provision of a timely alternative permanent placement for MFC children who cannot be returned to their family of origin;
- Ensure that families who are reunited with MFC children with continuing medical problems receive appropriate medical training in order to provide the care for their child prior to the return of the child; and
- Reduce the risk of medical neglect or abuse for children once they are returned to their own homes.

Legislative Authority

Title XIX of the Social Security Act, as amended by the Omnibus Budget Reconciliation Act (OBRA) of 1989 provides that children from birth through 20 years of age are eligible for services identified and prescribed as a result of the Well Child Check-Up, formerly called the Early and Periodic Screening and Diagnostic Treatment, regardless of whether the services are included in Florida's Medicaid State Plan. Implementation of the amendments of Title XIX resulted in the establishment of Medicaid-funded services to children with special health care needs including children with complex medical needs. AHCA administers the Florida Medicaid Program under Title XIX of the Social Security Act. DOH's Division of Children's Medical Services Programs (CMS) is the state's Title V Program for children with special health care needs. DOH, through CMS, provides medical services to medically complex and medically fragile children like MFC children.

Other laws that apply include:

- In accordance with Title VI of the Civil Rights Act, "No person will, on the grounds of race, color or national origin, be excluded from participation in, or be denied the benefits of, or be otherwise subjected to discrimination under this program";

- Chapter 39, Florida Statutes. Provides a definition of a dependent child and allows the removal of custody from the parents when the child's welfare and safety are threatened due to alleged abuse, neglect, or abandonment;

- Chapter 391, Florida Statutes. Enables CMS to provide medical services to eligible individuals. Eligible individuals include children with special health care needs that hinder their achievement of normal growth and development;

- Chapter 409.145, Florida Statutes. Gives DCF the responsibility for providing services to dependent children and their families and provides a definition of dependent children for whom services can be provided;

- Chapter 409.165, Florida Statutes. Mandates DCF to establish and supervise appropriate facilities to provide placement and care for dependent children;

- Chapter 409.1671, Florida Statutes. Mandates DCF to privatize foster care and related services statewide, and

- Chapter 409.175, Florida Statutes. Mandates that dependent children be placed in a foster home or facility licensed by DCF.

Medical Foster Care Rules and Standards

The following non-inclusive list of policies, rules, and standards apply to MFC:

- DCF, Community Based Care Statewide Operating Procedures or the Community Based Care Lead Agency Operating Procedures;
- DOH, Division of CMS Programs Operational Policies and Procedures;
- Chapter 59G-4.197, Florida Administrative Code; Medical Foster Care. The Agency for Health Care Administration provides for the incorporation of the Florida Medicaid Medical Foster Care Services Coverage and Limitations Handbook and the Florida Medicaid Reimbursement Handbook and other applicable Medicaid rules from Chapter 59G, such as definitions and eligibility;
- Chapter 65C-13, Florida Administrative Code; Foster Care Licensing;
- Chapter 65C-28, Florida Administrative Code; Out-of-Home Care. The Department of Children and Families provides for the referral and coordination of Medical Foster Care Services for children in out-of-home care suspected or identified as having a medical special need as a placement matching requirement in 65C-28.004, and
- Chapter 65C-29, Florida Administrative Code; Protective Investigations.

CMS Complaint and Grievance Process

The DOH CMS Complaint and Grievance process should be offered to any provider, agency, or biological parent who expresses verbal or written expression of dissatisfaction regarding the administration or provision of services. Chapter 6 contains specific information regarding the Complaint and Grievance process for MFC parents.

Chapter 2 ADMINISTRATIVE PROCESS

Inter-Agency Central Office Coordination

The MFC Program is administered by DOH, Division of Children's Medical Services (CMS). The MFC Program is truly an interdepartmental service in which CMS, AHCA, Medicaid Services, and DCF and its privatized community-based service providers all deliver services jointly to MFC children. Collaborative services under the MFC Program include:

- Medicaid enrollment of MFC parent providers;
- Medicaid reimbursement to MFC parents for providing medically-necessary services to MFC children;
- MFC parent recruitment and training;
- Medical and social work care coordination and collaboration;
- 24-hour nursing care coordination for MFC children by CMS;
- MFC child placement;
- Board rate by CBC, and
- Reunification and adoption case management services provided by the CBC and CMS.

A successful MFC Program in the local community requires communication and collaboration at all service levels.

The following section contains collaborative responsibilities for the headquarters' office staff in the development, administration, and on-going technical assistance and monitoring responsibilities of the MFC Program.

As necessary, representatives from AHCA, DOH, and DCF will meet to:

- Establish and revise statewide MFC Program standards;
- Develop and revise the MFC Statewide Operational Plan;
- Provide program-specific policy interpretation and oversight over the MFC Program in order to achieve statewide consistency;
- Coordinate and communicate with the Child Protection Team and attend Child Abuse Death Review meetings as requested;
- Conduct technical assistance and quality improvement validation monitoring for area programs to ensure good practice, compliance, and accountability with statewide program standards and state and federal laws;
- Assist the CMS Central Office staff with data analysis;
- Assist the CMS Area Office with area needs assessments;

- Provide direction and program-specific materials for establishing training protocols and standards, and

- Provide direction and interface to Medicaid area offices, DCF area offices and their contract providers, and CMS area offices, regarding MFC services or the reimbursement for medical services.

Statewide MFC Physician Consultant

The statewide MFC physician consultant will be a CMS-approved pediatrician appointed by the DOH Deputy Secretary for CMS. The statewide MFC physician consultant will assure that each local MFC Program has strong and available medical direction which addresses each MFC child's medical needs. The statewide MFC physician consultant will provide statewide consultation to local treating physicians caring for MFC children and CMS Central Office staff regarding the MFC Program.

Statewide MFC Nurse and Social Service Consultants

The statewide MFC nurse and social service consultants will take lead in all interagency central office coordination activities listed above. They are responsible for maintaining the MFC budget and requesting additional funds as well as programmatic contract management and quality improvement activities. They provide statewide consultation to CMS area offices and MFC staff regarding the MFC Program.

Statewide Medical Foster Care Regional Trainers

Medical Foster Care nurses (RN) and MFC social service workers (SW) may request the permission of their supervisors to serve as MFC regional trainers. This role should be added to the employee's job description. Regional trainers must have received prior train-the-trainer instruction provided by DOH regarding the delivery of the Medical Foster Parent Pre-Service Training course, be knowledgeable in the current curriculum and use of current presentation software, and receive mentoring from an experienced trainer.

When the local area MFC staff contacts the CMS Central Office social service consultant to request training for prospective MFC parents; SW and RN regional trainers will be selected based on their availability and proximity to the local area in which training is needed. When the trainers are identified, the SW regional trainer will serve as the training coordinator and will contact the local area MFC staff that requested the training. Detailed procedures and position responsibilities are outlined in the Medical Foster Care Parent Pre-Service Training Procedures and Responsibilities (see **Attachment I**).

Inter-Agency Local Area Office Coordination

In each area where the MFC Program has been established; DOH's local CMS area office or its MFC contract providers will provide the day-to-day operation of the MFC Program to include adequate staff to provide medical oversight of the program in accordance with the current MFC Statewide Operational Plan. DCF's CBC Program will provide foster care services to children and families served by the MFC Program. AHCA's Medicaid Program will provide Medicaid services to MFC children and MFC parents. Staff from each of these programs will communicate, collaborate and coordinate their services to ensure that quality services are provided to MFC children.

DCF through CBCs and their Contracted Provider Responsibilities

- DCF will provide or contract with the local Sheriff's Office for child protective investigation (CPI) services.

- The CPI or CBC will refer all foster children with medical needs to the local area CMAT for assessment and staffing as appropriate;

- CBC will provide placement, permanency planning, reunification, and adoption activities to the dependent child served in the MFC Program;

- The child's CBC case worker will collaborate and communicate with the MFC staff to ensure that the child's medical needs are met and that the knowledge and skill requirements of the caregiver in meeting the child's needs are addressed and appropriately included in the permanency goals established in the child's case plan;

- The child's case worker will provide MFC staff with a copy of all legal documents including court orders and case plans;

- The child's case worker will advise MFC staff of any significant events that could impact children in medical foster homes;

- The child's case worker will share with the MFC staff any information necessary to ensure that medically necessary services for the child in MFC are not delayed or denied;

- The CBC will provide for the recruitment and retention of foster homes that participate in the MFC Program and share information with MFC staff regarding these homes;

- In coordination with the DCF Regional Director; the CBC will provide pre-service training, foster home licensing, and re-licensing activities for foster homes and parents who participate in the MFC Program;

- The CBC will participate in Children's Multidisciplinary Assessment Team (CMAT) staff meetings for children who are being staffed for Medical Foster Care, and

- The CBC will provide an overview of their foster care program services, the role of the child's dependency case worker, licensing of foster homes, and permanency planning to MFC staff.

DOH, through CMS and their Contracted Provider Responsibilities

- Provide CMAT assessment and staffing services;

- Obtain consent for evaluation, treatment, and release of information on the appropriate DOH letterhead. In addition to these consents, contracted MFC programs will obtain consent for evaluation, treatment, and release of information on the contractor's agency letterhead. This will allow the contractor to provide care coordination services and to release information to CMS and other care providers. Other consents and acknowledgements may also be required per the contractual language;

- Provide medical oversight, nursing and social work care coordination and supervision for the MFC Program;

- Provide comprehensive documentation of care coordination services;

- Provide timely information to the MFC child's CPI or CBC case worker regarding the child's medical needs to ensure the court system receives the information in order to make decisions about the child's status;

- Assist the CBC in recruitment and retention of foster parents who choose to participate in the MFC Program and share information regarding these homes with the CBC licensing staff;

- Coordinate the MFC Parent Pre-Service Training with CMS Central Office MFC consultants and approve foster parents who will participate as MFC parents, and

- Provide input to the CBC licensing staff for licensing and re-licensing of medical foster homes.

Medicaid Program and their Contracted Provider Responsibilities

- Participate in CMAT staffings for MFC children;

- Approve MFC parents as Medicaid providers;

- Provide training to MFC parents on Medicaid claims submission and billing processes;

- Provide prior authorization for MFC services;

- Provide technical assistance to MFC Program staff, MFC parents, and medical providers to resolve Medicaid reimbursement issues, and

- Participate in technical assistance visits, program reviews, review of the medical foster parent provider responsibilities and quality assurance activities, as time and budget permit.

Chapter 3 MEDICAL FOSTER CARE PROGRAM PERSONNEL

Staffing Requirements for MFC Programs

While additional staff may be added based on program size and regional-specific needs, each local area MFC Program will have, at a minimum, the following MFC staff available to provide direct services:

- Registered nurse (RN). One full time equivalent (FTE) RN per 22 MFC children serving as the local area MFC RN. Minimum qualifications for this position include:
    - Licensed registered nurse in Florida.
    - Preference for experience in care coordination/case management, public health/school nursing, pediatric primary/specialty outpatient care, pediatric hospital, working with families, children, and/or children with special health care needs/disabilities.

- Social service worker (SW). One FTE SW per 30 MFC children serving as the local area MFC SW. Minimum qualifications for this position include:
    - A bachelor's degree in a human services field of study such as social work, psychology, or counseling and three years of professional social work or related experience.
    - A master's degree in a human services field of study such as social work, psychology, or counseling can substitute for two years of the required experience.

- RN supervisor. Percent of FTE to be determined by program needs serving as the local area MFC Program supervisor;

- CMS-approved physician Medical Director (MD). Ten percent (.10) FTE of a CMS-approved physician per 22 MFC children serving as the local area MFC Program MD; and

- MFC Program coordinator. Percent of FTE to be determined by program needs. For area MFC teams with one RN, this role is usually performed by the MFC SW.

- MFC contracted programs are allowed a percentage of an FTE for administration and oversight.

At times, a MFC Program may be faced with having to serve MFC children when the ratio of MFC children to staff is over the suggested ratio. This situation may happen when one or two admissions or discharges did not occur as planned or when a MFC staff person is on leave or the program experiences a staff vacancy. When this occurs, the MFC Supervisor and MFC MD must review the current caseloads to determine that on-going care coordination services can be provided for each child in the program. If the staffing shortage cannot be resolved; new admissions to the program should be closed until additional staff can be recruited and trained.

In areas serving fewer than 22 MFC children, it is not anticipated that a full-time RN and SW would be required. In these areas, the CMS nursing director may assign additional duties to the RN and SW designated for MFC, adjusting the FTE to fit the workload but keeping MFC responsibilities a priority. The percentage of RN supervisor services may be assigned by the CMS nursing director based on the MFC Program size.

MFC Staff Orientation Requirements

All MFC staff members must receive, at a minimum, the following training within the **first six (6) months of employment**:

- An overview of DCF and the CBC Program in the local service area to include foster care program services, understanding of the role of the child's case worker, licensing of foster homes and permanency planning;
- MFC staff who have not had previous foster care work experience in DCF or CBC programs are required to complete a DCF-approved parent preparation training course required of prospective foster and adoptive parents;
- Participation in a MFC Parent Pre-Service Training course;
- Participation in Medicaid's provider training for Medicaid claims submission and billing processes;
- Participation with the MFC statewide consultants in a formal monitoring of a local area MFC Program;
- An orientation to CMS;
- An orientation to the CMAT process with Validated Level of Reimbursement Tool training and the current CMAT Statewide Operational Plan;
- An orientation to MFC services and the current MFC Statewide Operational Plan;
- An orientation to the MFC section of the Medicaid Summary of Services and the current Medicaid MFC Services Coverage and Limitations Handbook;
- Instruction in the development of a MFC plan of care;
- Instruction in nursing care coordination for nursing staff;
- Instruction in social work care coordination for social work staff;

- Instruction in MFC program coordination and orientation to the MFC administrative records for staff who will serve as the MFC program coordinator;
- Instruction in use of the current CMS-approved documentation system;
- Cultural diversity Training;
- DOH Security Training, and
- Health Insurance Portability and Accountability Act (HIPAA) Training.

The MFC Program supervisor or designee should arrange all of the above-mentioned training locally and with the MFC consultants, as appropriate. All of the instruction, training, and orientation listed above provided to the staff person will be documented, dated, and filed in the employee's personnel file.

Personnel Roles and Responsibilities

DOH personnel policies and procedures apply to all MFC Program staff. MFC staff are responsible for protecting the health information of MFC children from unauthorized modification, destruction or disclosure and for safeguarding sensitive and confidential information.

CMS Nursing Director and Contract Program Administrator

For local area MFC programs not run by contracted providers, the CMS nursing director will have overall responsibility for program adherence to operational plans, rules and policies and for supervision of the MFC Program. Day to day direct responsibility may be delegated by the CMS nursing director to the CMS RN supervisor. The CMS nursing director will also be available to provide consultation to the area contract program and assist in any communication and coordination between programs that is deemed necessary.

For contracted programs, overall administrative program oversight is provided by an administrator identified by the contract. The delivery of direct MFC services is the responsibility of the MFC MD and the MFC RN supervisor with close communication and coordination with the contract program administrator.

Medical Foster Care Program Coordinator

Each local area MFC Program will have a designated staff member who will serve as the MFC program coordinator. The program coordinator is responsible for ensuring that MFC parents and homes meet MFC Program standards. Program coordination includes but is not limited to:

- Coordinating all administrative day-to-day operations of the MFC Program;
- Maintaining the MFC administrative records;
- Maintaining MFC data and preparing reports;
- Providing assistance in the recruitment of MFC parents;
- Coordinating activities related to the screening and training of prospective MFC parents;
- Assisting parents with Medicaid enrollment and billing processes;
- Requesting Medicaid prior authorization;
- Providing assistance in the retention of MFC parents;
- Coordinating and tracking in-service MFC parent training;
- Providing administrative support and guidance for medical foster families;
- Confirming that the annual and on-going parent skill assessments and related corrective actions are completed by the RN and SW;
- Completing the annual and ongoing medical home evaluations and related corrective action; in coordination with the RN, SW, and MD.
- Acting as the MFC program liaison with other community providers, and
- Raising community awareness of MFC services.

See Chapter 4 under “Program Coordination in MFC” for details of these requirements.

Medical Foster Care Medical Director

The MFC medical director will be a pediatric CMS provider appointed by the local CMS area office medical director and approved by the CMS Deputy Secretary. All MFC medical directors will designate a back-up MFC medical director in their absence that must also be a pediatric CMS provider and approved by the CMS area office medical director. Responsibilities of the MFC MD or their MD designee will include but not be limited to:

- Reviewing each MFC child’s medical record including the plan of care and current medical orders;
- Attending regularly scheduled meetings with MFC staff;
- Monitoring each MFC child’s health status;

- Providing medical direction for the MFC Program;
- Providing consultative services;
- Notifying DCF or its CBC provider regarding a child who is at risk or is experiencing a significant medical condition(s) in which loss of life may occur;
- Determining Level of Reimbursement for MFC children when necessary;
- Reviewing the child's health status, prescribing MFC services and recommending the placement of each MFC child into a particular MFC home. MFC Program personnel will request placement authority from the CBC;
- Participation in dispute resolution activities regarding the recommended placement of MFC children;
- Reviewing the on-going quality and appropriateness of MFC services and home requirements provided by MFC parents;
- Approving MFC parents and homes that meet MFC program standards;
- Providing corrective action to MFC parents when needed;
- Determining if a MFC parent should be withdrawn from the MFC Program, and
- Documenting the above activities in the appropriate record.

See Chapter 4 under "Medical Direction in MFC" for details of these requirements.

Medical Foster Care Registered Nurse Supervisor

The RN supervisor will have direct responsibility for program adherence to the MFC Operational Plan and related rules and policies. Activities will include but not be limited to:

- Supervision and on-going training of the MFC staff;
- Support and technical assistance to MFC staff and MFC parents;
- Attending regularly scheduled meetings with MFC staff to discuss issues related to the MFC child's care needs;
- Oversight of quality assurance and improvement in the MFC program, and
- Timely communication with the MFC statewide consultants regarding MFC program issues.

See Chapter 4 under “Supervision of the MFC Program” for details of these requirements.

Medical Foster Care Registered Nurse

Responsibilities of the MFC RN will include but not be limited to:

- Conducting comprehensive nursing assessments of MFC children;
- Developing and maintaining up to date plans of care;
- Requesting Medicaid prior authorization, as necessary;
- Providing nursing interventions and care coordination;
- Making home and community visits;
- Providing child-specific information and education regarding MFC children’s health issues to persons with a need to know;
- Providing information regarding what any caregiver needs to know to care for the MFC child to the child’s foster care case worker;
- Participating, in conjunction with the MFC SW and the child’s foster care case worker, in court hearings to provide testimony and input to the court, when necessary;
- Requesting court orders as needed;
- Providing consultative services;
- Accompanying children, as necessary, to clinics;
- Approving MFC babysitters;
- Assisting with obtaining private duty nursing;
- Assisting caregivers in developing the competencies needed to safely meet the medical needs of MFC children;
- Verifying the child-specific training of all caregivers;
- Providing nursing and emotional support to MFC parents;
- Providing follow-up visits for nursing care coordination for children who have been discharged from the MFC program;
- Participating as a CMAT member for all foster children’s staff meetings as needed;

- Providing a CMAT nursing assessment of MFC children, when requested by the CMAT;
- Providing the CMAT with timely updates regarding MFC children's medical conditions and care needs;
- Assisting in the recruitment and retention of MFC parents;
- Participating in Medical Foster Parent Pre-Service Training and screening of prospective MFC parents;
- Supervising the in-home record keeping of MFC parents;
- Observing the condition of the medical home;
- Providing teaching (technical) assistance to MFC parents and prepare corrective action plans when necessary;
- Completing a written evaluation of each MFC parent's care giving skills, in coordination with the MFC SW, and
- Documenting the above activities.

See Chapter 4 under "Care Coordination and Timeframes in MFC" for details of these requirements.

Medical Foster Care Social Service Worker

Responsibilities of the MFC SW will include but not be limited to:

- Conducting comprehensive psychosocial assessments;
- Developing and maintaining up to date social work plans of care;
- Requesting Medicaid prior authorization, as necessary;
- Providing social work interventions and care coordination;
- Making home and community visits;
- Providing child-specific psychosocial information and education regarding MFC children to those with a need to know;
- Participating, in conjunction with the MFC RN and the child's foster care case worker, in court hearings to provide testimony and input to the court, when necessary;
- Requesting court orders, when necessary;

- Providing consultative services;
- Accompanying children, as necessary, to clinics;
- Assisting caregivers in developing the competencies needed to safely meet the psychosocial needs of MFC children;
- In coordination with DCF or CBC, referring the child or the family of origin to community resources for additional services;
- Assisting with parental and sibling visitation and supervision for MFC children;
- Providing social work and emotional support to MFC parents;
- Providing follow-up visits for social work care coordination for children who have been discharged from the MFC program;
- Participating as a CMAT member for all foster children's staff meetings;
- Providing a CMAT psychosocial assessment of MFC children, when requested by the CMAT;
- Providing the CMAT with timely updates regarding MFC children's psychosocial status;
- Assisting in the recruitment and retention of MFC parents;
- Participating in Medical Foster Parent Pre-Service Training and screening of prospective MFC parents;
- Observing the condition of the medical home;
- Providing teaching (technical) assistance to MFC parents and prepare corrective action plans when necessary;
- Providing a written evaluation of each medical foster parent's care giving skills, in coordination with the MFC RN, and
- Documenting the above activities.

See Chapter 4 under "Care Coordination and Timeframes in MFC" for details of these requirements.

Medical Foster Care After-Hours On-Call Staff

There will be one registered nurse on-call 24 hours a day, seven days a week available to the MFC parents who are currently caring for MFC children and for after-hour referrals of children to the MFC Program. The after-hours on-call staff must include the MFC RN(s) and may be rotated among the CMS nursing director and the MFC RN supervisor. The CMS nursing director will determine whether or not to allow other CMS RN staff to participate in the MFC after-hours on-call schedule. See Chapter 5 under “On-Call Work in MFC” for specific requirements.

Chapter 4 SERVICE DELIVERY PROCESS

Eligibility for Medical Foster Care Services

To be eligible for MFC services the child must meet all of the following criteria:

- Be between the ages of 0 through 20 years with a medically complex or medically fragile condition;

  A "medically complex condition" means that the person has a chronic debilitating disease or condition of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing or health supervision or intervention. (FAC 59G-1.010) This does not mean that the child must require interventions by a medical professional every hour of the day.

  A "medically fragile condition" means that the individual who is medically complex and whose condition is of such a nature that they are technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning. (FAC 59G-1.010)

- Be in the custody of DCF through court order or a voluntary placement agreement as outlined in Chapter 65C-15 in the Florida Administrative Code or be in extended foster care. This is a requirement prior to consideration for placement or continuance in MFC;

- Be referred to the CMAT and recommended for the MFC Program based on the levels of reimbursement (see Children's Medical Services CMAT Operational Plan);

- Have MFC services prescribed by the MFC MD;

- Be medically stable for care in the home setting at the time of placement, as determined by the MFC MD, and not in need of acute hospital care. If the MFC MD determines that the child is not medically stable, the CMAT and foster care case worker will be notified and provided with an explanation as to why placement in the MFC Program is not an option at this time;

- Have written consent granted by the parent, guardian, legal custodian, or court for CMS or it's contracted provider to provide medical care and release information;

- Be eligible for Medicaid services upon placement in a medical foster home, and

- Continue to be eligible for MFC services as long as they remain in the MFC Program and continue to meet the criteria of medical necessity and Level of Reimbursement. There is no established "time limit" for MFC services except by reason of age. The child may transition to regular foster care or to another type of placement if their health status improves and they no longer qualify for MFC services.

Examples of children who are considered candidates for the MFC Program include, but are not limited to, the following:

- Foster children who, may be generally medically stable in a home environment, have high technological needs for therapies, treatments, equipment, continuous observation or monitoring (e.g., children with long-term tracheotomies, feeding gastrostomies, intermittent or continuous ventilator support and children requiring total parenteral nutrition);

- Foster children hospitalized for a change in medical management, counseling or adaptation (e.g., the out-of-control diabetic or asthmatic child who can no longer be managed effectively by their parents);

- Foster children recuperating from complicated surgery or accidents whose illness involves a prolonged recovery during which time skilled nursing and medical care is required;

- Foster children "in transition" from tertiary centers to home care (e.g., children who are generally medically stable but their parents or caregivers require a setting in which to learn the technical and developmental aspects of their care management), and

- Foster children in the custody of DCF and who may be "at risk" (e.g., failure to thrive, HIV).

Types of Medical Foster Care Placements

1. Involuntary Placements - Children placed involuntarily into the MFC Program must be in the custody of DCF. These children may be placed in the MFC Program while they are in emergency shelter status and prior to a judicial disposition to foster care.

2. Voluntary Placements - Voluntary placement into the MFC Program may be available to children who qualify for voluntary foster care placement through the CBC. This is accomplished through a voluntary placement agreement between the child's parent or legal guardian and the CBC. Voluntary placement may be appropriate when:

- The parent, guardian or legal custodian has requested voluntary placement because the child's medical complexity is such that the parent, guardian or legal custodian is unable to provide the necessary care for the child and has determined that the child would benefit from temporary placement outside the home, and

- It appears that the conditions necessitating the voluntary placement can be resolved and reunification can occur within 180 days or less.

3. Extended Foster Care – "My Future, My Choice" - Young adults ages 18 – 21 in extended foster care who qualify medically for the MFC Program, may be served by the MFC Program through their 20th year.

Eligibility of Children with Psychiatric or Behavioral Problems

Children with psychiatric or behavioral problems who also have complex medical needs should be recommended for the MFC Program if their psychiatric or behavioral needs can be met in a medical home setting. It should also be recognized that special health care needs may have an impact on the behavioral and emotional health of children. At the initial CMAT staffing, if the child's nursing and psychosocial assessment reveals that the child's psychiatric or behavioral needs cannot be met in a medical home setting, the child should be referred to other agencies for appropriate services. If, after placement of the child in MFC, the child's behavior cannot be managed in a medical foster home setting, the child's foster care case worker must be notified so that the child can be transferred to a more appropriate setting. Additionally, the child must be referred back to the CMAT for evaluation of the need for other medically necessary services in the new setting and for transition and discharge planning from the MFC Program.

Dually-Qualified MFC Therapeutic Foster Homes

Dually-qualified MFC Therapeutic homes are a solution in many cases for foster children with both medically complex and behavioral conditions. Each local area MFC Program will need to come to an agreement with their lead CBC agency in order to determine how best to develop and manage these homes in the local area. Foster parents must meet the eligibility requirements for both Specialized Therapeutic Foster Care (STFC) and Medical Foster Care. Children who qualify for both programs will receive respective care coordination and services from both programs simultaneously. The more restrictive requirements of both programs must be honored, such as the STFC limitation of no more than two foster children at a time in the home.

Communication and Coordination with CMAT

The MFC Program staff has the following responsibilities to the CMAT:

- When the MFC staff receives a referral from the CMAT, the MFC staff must provide written notification of the disposition of the referral within five (5) calendar days to the CMAT and the child's CPI or CBC case worker. For placements into MFC, the MFC Medical Director Recommendation form will be used (see **Attachment II**);

- If the MFC services are not available due to the lack of an appropriate placement for the child, or a waiting period is expected prior to a placement opening, or the child continues in a hospital placement, the MFC staff must notify the CMAT of this. If the child is placed when a bed becomes available, the MFC staff must notify the CMAT staff as soon as possible;

- When a MFC child is discharged from the program via court order, written notification to the CMAT is required within five (5) calendar days of the discharge by way of a completed MFC Medical Director Recommendation form. A CMAT staffing may be necessary to review current information and make a recommendation regarding the most appropriate services post discharge;

- Due to extenuating circumstances, by exception, MFC staff may provide a nursing and psychosocial assessment to the CMAT if requested by the CMAT for children currently in the MFC Program. These assessments will be documented on the CMAT Assessment format;

- MFC staff will participate as a member of the CMAT in the staffing process for ALL foster children. One MFC staff member must participate as a voting member; there may be times during which MFC staff will not be available to participate in these staffings, however, every attempt should be made to participate;

- MFC staff, as care coordinators, will participate in the CMAT staffing process for MFC children during the child's placement and provide the CMAT with significant changes or events that can affect the child's Level of Reimbursement (LOR), and

- If, during the course of care coordination, it is suspected that the child's LOR has changed, the MFC staff is responsible for referring the child to the CMAT for another staffing. When the MFC staff assess that the MFC child may no longer meet a LOR, MFC staff must refer the child to the CMAT for a potential discharge staffing.

Exceptions to the CMAT Staffing Process

CMAT Unable to Perform Emergency or Urgent Placement Staffing

Occasionally, the CMAT cannot convene an emergency staffing within five calendar days, or 48 hours for urgent placement needs. When this occurs, the CMAT will send a written request to the MFC staff for the MFC staff to determine the foster child's eligibility for MFC services and a temporary LOR. This request will include the reason why a staffing cannot be convened by the CMAT within the required timeframe. The CMAT supervisor must approve this action and document this approval in the child's Record of Treatment notes. If the MFC staff is available to process the referral for the CMAT, the MFC staff will promptly arrange to:

- Obtain release of information and consent to treatment information, if necessary,

- Obtain the necessary medical information to determine the child's medical needs that must be included in the assessment of the child;

- Discuss the medical assessment information with the MFC MD. The MFC MD will determine, (1) if the child's needs can be met in a medical foster home, (2) if the child is eligible for MFC services, and (3) assign a temporary LOR. The LOR is determined by completing the Validated Level of Reimbursement Tool and will result in one of the following:

    - Level One (I) – the child is at risk for or is experiencing infrequent and predictable changes in medical needs. The child's medical needs require simple interventions, medical management, reliable observation and documentation by a trained caregiver.
    - Level Two (II) – the child is experiencing frequent and predictable changes in medical needs or infrequent and unpredictable changes in medical needs. These needs can be met by a caregiver who is prepared to meet both anticipated and unanticipated events.
    - Level Three (III) – the child is experiencing frequent and unpredictable changes in medical needs. These needs can be met in the home setting by a caregiver who is prepared to intervene when the child experiences anticipated and unanticipated events.

  If the available medical information is not sufficient to make the determinations listed above, the MFC MD will obtain additional information before recommending placement;

- Forward the assessment information and outcome of the referral to the CMAT so that a CMAT initial staffing can be scheduled. If the child will be placed in a MFC home, the outcome of the referral is to be documented on the MFC Medical Director Recommendation form and forwarded to the CMAT, and

- Document the above information in the current CMS-approved documentation system as soon as the child's information is accessible in the system.

The temporary LOR must be recorded on the child's plan of care. The effective date of the LOR will be the date the child is placed in the MFC home. The temporary LOR determination will remain in effect until a CMAT recommendation can be obtained. The CMAT will hold an initial staffing within 30 calendar days of the referral or receipt of the necessary consent forms, whichever is later.

If the MFC staff is not available to determine the child's eligibility for MFC services and a temporary LOR, they will notify the CMAT in writing on the day the request was received. This notification must include the reason why they are not available to make this determination. The CMAT will then process the referral and conduct an emergency staffing as quickly as possible, but no later than the five calendar days required for emergency staffings.

After Hours Referrals to MFC

When the MFC on-call RN receives an after-hours referral to the MFC Program, the MFC MD, or another licensed physician designee, may make a temporary LOR determination and placement recommendation. After-hours placements are appropriate only for children who are known to the MFC Program staff and sufficient medical information is available for a determination to be made.

The CMAT will be notified of the referral and determination on the following business day. This must be documented on the MFC Medical Director Recommendation form in order for an initial CMAT staffing to be scheduled and held within 30 calendar days. If the child is eligible for MFC, the MFC MD's after-hours recommendations will be honored by Medicaid. The temporary LOR determination will prevail until a CMAT recommendation can be obtained.

See the "Medical Foster Care Admission and Placement Process" later in this chapter for detailed admission procedures.

Medicaid Observation Services

Medicaid Observation Services are services that are reasonable and necessary to evaluate a child's condition or determine the need for a possible admission to the hospital. Medicaid reimburses up to 48 hours for Observation Services. Observation Services are used when it is determined to be in the best interest of the child in order to complete the MFC admission process including sign-off on the MFC Care Plan, acquisition of medication and equipment, and child-specific training of the MFC parent.

On occasions when the child is referred to the hospital for Observation Services admission, the evaluating hospital physician may determine that the child is not in need of Observation Services. If this occurs, the MFC staff will consult with the MFC MD for recommendation regarding placement options for the child. This Medicaid policy is outlined in the Medicaid Hospital Services Coverage and Limitations Handbook.

Out of Area MFC Referrals and Admissions

The MFC Program is a statewide program that is required by policy, to serve all MFC-eligible children, regardless of the child's legal jurisdiction or county of residence. The only exception to this policy is when there is not a MFC bed available to admit a referred child. When a MFC-eligible child is temporarily outside of their legal jurisdiction and needs any MFC service, such as an assessment or verification of child specific training, the child's home MFC team must request the needed MFC service from the MFC team where the child is physically located. The needed service shall be provided to the child as a courtesy to the child's home MFC team.

Out of Area MFC Admission Process

MFC staff has the responsibility to coordinate with the child's CBC case worker to determine if they are interested in an out-of-area MFC placement in instances where the CMAT has referred a child for MFC services and no placement is available in the local program area.

If the approval for out-of-area placement **is not** given by the CBC, the MFC staff will notify the CMAT in writing regarding this determination. Documentation of the outcome must include the name of the CBC contact and will be placed in the child's notes in the medical record. In addition, it must be entered in the MFC data as, "Referred but not placed". If the child does not have a medical record at the time, a folder must be opened under the child's name documenting the information.

If the approval for out-of-area placement **is** given by the CBC, the local MFC staff will contact other area MFC programs to determine if a placement would be possible by way of email without using any child identifiers to the statewide MFC nurses, social service workers, and supervisors' distribution lists.

MFC staff must notify the referring CMAT of each out-of-area placement in the MFC Program. Communication and coordination between the respective MFC, CMAT and CBC staff is essential for smooth transitioning and placement of a MFC child outside of their legal jurisdiction. This is a shared responsibility between both the sending and receiving areas.

Prior to accepting an out-of-area MFC referral, the receiving MFC staff must obtain the child's CMAT assessment, staffing summary, and the MFC assessment. Once the receiving MFC staff has identified a placement, the sending MFC RN must visit the child and conduct an in-depth assessment. Final authority to place a child with a specific medical foster family remains with the CBC. The receiving MFC RN is responsible for developing the initial Plan of Care. It is essential that communication regarding each out-of-area placement between both the sending and receiving CBC has occurred, and all appropriate parties have full knowledge of the transfer and have approved the placement recommendation of the MFC MD. The sending MFC staff will

provide the receiving MFC staff with the child's CBC case worker's contact information. It is essential that the receiving MFC staff request from the child's sending CBC case worker the following information:

- The name of the child's courtesy CBC case worker in the receiving area;
- Request that the CBC staff notify Medicaid of the child's new address, and
- A determination of the approved visitation arrangements for the child and their birth family.

Once the above activities have taken place to the satisfaction of all involved parties, the child may be transferred to the receiving area. A child-specifically trained caregiver must accompany the child during transportation.

Obtaining Medicaid Prior Authorization

In order to receive prior authorization from Medicaid, the MFC staff must submit the following documents to the area Medicaid RNS:

- A copy of the plan of care, that includes the dates of service for which authorization is requested, signed and dated by the MFC RN and the MFC MD;
- The MFC parent's Medicaid provider number, name and address, and
- A copy of the CMAT summary, except in instances where the LOR is determined by the MFC MD.

Medicaid must receive requests for initial authorization within 10 days of the initiation of service. If requests are not received by Medicaid within the required timeframes, reimbursement will be denied until documentation is received.

Subsequent requests for prior authorization must be received by Medicaid prior to the expiration of the previous prior authorization in order to avoid gaps in the MFC parent's billing cycle.

The Medicaid RNS will send the MFC parent and the MFC staff a prior authorization verification letter indicating the status of the request.

Changes in Level of Reimbursement

Changes in LOR for children currently receiving MFC services will be retroactively authorized to the day after the CMAT staffing. If a LOR is determined by CMAT to have changed, a new prior authorization is required, as well as a new plan of care. For changes in LOR, Medicaid must receive authorization requests within 10 days of the change in the LOR.

The Medicaid RNS will send the MFC parent and the MFC staff a prior authorization verification letter indicating the status of the request.

If the CMAT decides to discharge the child from the MFC Program due to the child's improved condition and no LOR is assigned and the child remains in the MFC home, the child will remain active in MFC Program for 10 days following the CMAT staffing, to allow for an appeal of the decision to discharge the child from a Medicaid program. If no appeal is filed the child must be discharged from MFC 11 days following the CMAT staffing. Of course, if the child does not remain in the MFC home, the child must be discharged from the MFC Program when they leave the home.

Medical Foster Care Admission and Placement Process

When admitting a child into the MFC Program, the following activities must occur:

- Receive the referral for MFC services from the CMAT, including the CMAT Assessment and CMAT Staffing Summary, or from the MFC MD with the LOR assigned to the child;

- Verify that the child is in the custody of DCF with a copy of the child's current court order identifying that the child is in the custody of the department, or a copy of a Voluntary Placement Agreement initiated by the DCF or CBC and signed by the birth parent, legal guardian, or legal custodian of the child;

- Obtain consent for treatment and release of information signed by the child's birth parent, legal guardian or legal custodian;

- Verify that the child is enrolled in CMS with a copy of the child's current signed CMS Client Information Form / Application with the child's CMS enrollment date listed;

- Complete face to face nursing assessment and a psychosocial assessment to identify the child's care needs in the home setting prior to making the MFC home placement recommendation. If the child has not been entered into the current CMS-approved documentation system, these assessments must be handwritten, on a printable version of the assessment form. This form is available in the current CMS-approved documentation system;

    - The initial nursing assessment of the child must be completed comprehensively, prior to the child's MFC placement date with the exception of immunizations, which must be assessed within 30 days of admission to MFC. If the child is coming from a medical facility which is not in the area where the MFC placement is occurring, a courtesy assessment must be requested to be completed by the MFC RN in the area of the medical facility, as is done for out-of-area referrals.

    - The initial psychosocial assessment must be completed as comprehensively as possible prior to the child's MFC placement date. At a minimum, the child's behavioral needs and the MFC parent's capacity to care for the child must be

assessed prior to admission. The psychosocial assessment must be completed comprehensively within 30 days of admission to MFC.

- Obtain the child's Medicaid card or emergency temporary eligibility form accepted by Medicaid providers;

- Discuss with the MFC team, including the MFC MD, the best home placement in which the child's needs can be met. This discussion must ensure that all necessary orders are obtained, necessary tasks are identified, and tasks are assigned to the appropriate person. Good placement matching with the MFC family must include lifestyle and vacation preferences, to facilitate normalcy and inclusion of the child in family activities and vacations;

- Notify the child's CBC case worker of the recommended placement using the MFC Medical Director Recommendation form. Permission from the CBC must be obtained before the child can be placed;

- Arrange for the child's medical equipment, medications and any other additional services the child will need in the home;

- Develop the child's plan of care, using the CMS-approved documentation system. If the child has not been entered into the current CMS-approved documentation system, the first plan of care must be developed on the Temporary Plan of Care form (see **Attachment III**). This document must be signed by the MFC RN and MFC MD;

- Arrange for the MFC parent to receive child-specific training prior to the child's placement in the home;

- The MFC RN must verify that child-specific training of the caregiver has been completed prior to the child being left alone with that caregiver. For example, if the MFC child is being released to the MFC parent during discharge from the hospital, the child-specific training must be verified by a MFC RN prior to the child leaving the hospital with the MFC parent. Verification is documented on the MFC Child-specific Training Verification form (see **Attachment IV**);

- Prepare and review the child's in-home record with the MFC parent prior to or during the child's placement in the home;

- Forward to Medicaid, the necessary documents to request prior authorization for MFC services (see Obtaining Medicaid Prior Authorization section above);

- The MFC RN must visit the child in the MFC home within 24 hours of placement, except when the MFC RN was present during the MFC child's discharge from the hospital. In this latter case, the MFC RN must visit the child in the MFC home within 72 hours of placement. The purpose of the visit is to verify that the child has adjusted to their new home and all the child's needs are being met adequately;

- The MFC SW must visit the child in the MFC home within seven (7) calendar days of placement, and

- Document the above tasks in the current CMS-approved documentation system.

The child is considered admitted into the MFC Program when the MFC home has been identified, and the MFC parent is completing the child-specific training to care for the child who will be placed in the MFC home. This usually occurs either the day the child is placed, or the day before, when the MFC parent is receiving training. As part of the child-specific training, the MFC parent may be required by the hospital to "Nest" with the child in the hospital overnight prior to discharge. Children who have been assigned a LOR and referred to MFC may not be placed in a MFC home as a traditional foster child because the above activities have not yet been completed, in accordance with Medicaid Administrative Rule.

Admitting Children into MFC Who Are Not CMS-Enrolled

Many children referred to MFC are not enrolled in CMS and have a managed care Medicaid plan or other private insurance. In order to enroll children into CMS, MFC staff will submit a "CMS Client Information Form" (application) to the child's CBC lead agency. The CBC will take the necessary steps to dis-enroll the child from their current plan and enroll them into the CMS Network. Enrollment into the CMS Network will take place per Medicaid systems policy.

MFC services cannot be denied due to a child's managed care plan or private insurance assignment. If a child qualifies for MFC, then the child must be admitted into the program and the MFC parent provider must receive reimbursement for their services from the first day the child enters the home.

MFC services procedure codes S5145 HA (LOR I), S5145 TF (LOR II), and S5145 TG (LOR III) are not included in any managed care plan or private insurance in Florida. All MFC services are authorized by the Medicaid Area Office nurses and are reimbursed on a fee-for-service basis. Managed care organizations (all types) and private insurance are not involved with MFC services, and should not be consulted regarding admission or authorization.

After Hours Admissions

Prior to a child being admitted after hours, the following procedure must be followed. The on-call MFC RN will:

- Assess the child's medical needs and discuss with the MFC MD or designee;

- Obtain the MFC MD or designee's temporary LOR determination and placement recommendation;

- Obtain placement authority from the CBC;

- Obtain consent for treatment and release of information signed by the child's birth parent, legal guardian or legal custodian;

- Obtain verbal physician orders for the child;

- Develop a written plan of care, ensure that the medical foster parent is trained to provide the care to meet the child's needs and ensure that all necessary equipment is in the home;

- Coordinate transportation of the child to the medical foster home, and

- Must be present in the medical foster home when the child is admitted to the MFC Program after hours to validate child-specific training and ensure the above process.

On the next working day, MFC staff will forward the Medicaid Prior Authorization Request form for MFC services to the Medicaid RNS and notify the CMAT staff of the after-hours placement. The MFC RN should forward the assessment information and outcome of the referral to the CMAT. The outcome of the referral is to be documented on the MFC Medical Director Recommendation form, so that an emergency CMAT staffing can be scheduled. The temporary LOR determination will stand until a CMAT recommendation can be obtained. Under no circumstances can an after-hours MFC placement be made without the recommendation of the MFC MD, or their designee, and the approval of the DCF or CBC. The other documents and information necessary for admission can be obtained during the business week.

Other Placement Considerations

The MFC staff, in coordination with the DCF or CBC, will use the following placement considerations in recommending placement of children into MFC:

MFC Home Capacity

Medical foster care homes should not have more than three medical foster children or more than five children in total at one time. Dually qualified MFC/STFC homes should not have more than two foster children at one time. The number of children recommended by the MFC MD will not exceed the total foster home license capacity approved by the licensing authority, according to the requirements of ss. 409.175, Florida Statutes. Placement that increases the number of children beyond the maximum number for which the home is licensed must be recommended by the MFC MD, and a capacity waiver must be obtained from the DCF or CBC licensing authority, according to Chapter 65C-13, Florida Administrative Code. Capacity waivers are to be filed in the administrative record. Additional nursing oversight including frequent visitation to the home is required for all homes in which an over-capacity waiver is in force, and must be documented. In general, over capacity in medical homes is not recommended.

MFC MD Recommendation of Child Placement

The DCF or CBC child-placing agency staff will NOT place any foster child in a medical foster home without the recommendation of the MFC MD. The MFC parent will NOT accept any child, including extended family and friends into the medical home without the recommendation of the MFC MD. This requirement is necessary to be certain that medically complex children in the home will not be compromised by the presence of other children and to be certain that the healthy children will not be compromised by the illness or condition of medically complex children in residence. If a MFC parent accepts children into their home without the MFC MD's recommendation, the medical director may withdraw their approval of the MFC parent in the MFC Program.

All MFC MD recommendations for MFC transfers, MFC discharges, and for all other children entering the MFC home must be documented on the MFC Medical Director Recommendation form. See under "Transition and Discharge Planning" later in this chapter and Chapter 5 under "Child Transfers within MFC" for specific information.

Mixing Medical and Non-Medical Children in Medical Foster Homes

Mixing medical with non-medical children in medical foster homes is permissible and encouraged. At times, the MFC child is a member of a sibling group and the MFC parent is able to care for the healthy members of the group as well. Foster children who are unrelated to the MFC child may also be accepted into the MFC home. Some MFC parents simply feel that it is a better plan for their particular family situation to care for one MFC child and use remaining slots for healthy children. This is permissible and often works well.

Placement Disputes

In situations where there is a placement disagreement between the child's DCF or CBC case worker and the MFC MD's placement recommendation, the issues and concerns regarding the child's needs will be forwarded to the DCF Regional Director for resolution. If, after all concerns have been addressed and the MFC MD continues to have concerns regarding the medical care of the child or the MFC parent's ability to provide for the MFC child's care in the placement selected, the MFC child may be referred back to the CMAT for a determination of other medically necessary services to meet the child's current needs outside of the MFC Program.

Medical Direction in MFC

The role of the MFC MD, or their physician designee, is to provide medical oversight and direction for MFC children, approval of MFC parents, and serve as liaison for the MFC Program with other community agencies. Activities include but are not limited to:

- Determining LOR for foster children needing MFC services who are referred by the CMAT for this determination or by the DCF or CBC after hours. See under "Exceptions to the CMAT Staffing Process" earlier in this chapter for information regarding this policy;

- In coordination with the DCF or CBC, review and recommend the placement of each MFC child and the placement of all other children, including non-medical foster children and child relatives of the MFC family in a medical foster home. MFC child placement recommendations are based upon the parent's support system, ability to provide care, and the number of children already in the home as well as their care needs. MFC MD placement recommendations are made on the MFC MD Recommendation form;

- MFC placement recommendations will be made to the DCF or CBC and must not exceed the total capacity approved by the licensing authority according to the requirements of Chapter 409.175 or 393.067, Florida Statutes. See under "MFC Home Capacity" earlier in this chapter for more information;

- Participate in dispute resolution between the DCF or CBC and CMS or their contract provider regarding recommended placement of MFC children;

- Ensure medical continuity for each MFC child through communication with MFC staff and providers, and review of the medical record. This will reduce the possibility of medical errors and assure that the transcription of the orders, dosages and administration of the drug or treatment is correct. Any special considerations, such as monitoring parameters, drug interactions, route of administration and life threatening side effects shall be identified and discussed with the MFC staff;

- Ensure well child indicators such as immunization status to include recommended vaccinations for special populations, well child check-ups with updated growth charts, and dental visits for MFC children three years and older, or sooner if dental issues are noted;

- Review and approve the MFC plan of care as part of the medical record review. The MFC plan of care constitutes written instructions from the MFC MD to the MFC parent. These instructions must be clear, concise, and direct the activity of a lay-caregiver. The review of the medical record and approval of the plan of care, via MD signature is required;

- Following the review of each MFC child's medication, treatment, and equipment orders and a review of the child's plan of care, the MFC MD will document the review by signing and dating the electronic plan of care or the hard copy plan of care or in the notes or on an addendum to the plan of care, at least monthly. Additionally, there may be times when a review is needed due to a change in the MFC child's health care status;

- At least monthly, attend meetings with MFC staff to discuss the status of each MFC child. For each child, these meetings should occur prior to MFC placement, while the child is in MFC, and at least once following discharge. The purpose of these meetings is to review the child's current medical, developmental, and psychosocial status and discuss

recommendations from team members on how best to resolve problems and achieve goals. If the MD is unable to attend the regularly scheduled monthly meeting, then the meeting must be rescheduled during that month;

- Provision of consultation, as needed, to the MFC staff regarding changes in the MFC child's placement or health care status;

- When a child's condition warrants, immediately provide written notification to the DCF Regional Director, or their designee, and the child's foster care case worker regarding a child who is at risk or is experiencing a significant medical condition(s) in which loss of life may occur. The document should address the child's medical needs and condition, the LOR being provided and any other significant medical information regarding the child's short and long term prognosis;

- Provide updated information upon request to the child's foster care case worker so that they will have the current medical information to present for court reviews;

- Provide medical consultation to MFC parents, MFC staff, birth parents, CMAT staff, DCF or CBC staff, and other area physicians;

- Serve as the liaison between the MFC Program, the CMAT, the CBC's, the statewide MFC Physician Consultant, and the medical community;

- Meet with MFC staff on a regular basis to review and discuss MFC staff recommendations regarding new foster parents who have successfully completed medical foster parenting requirements. The MFC MD will also provide written notification of the approval of new medical parents to participate in the MFC Program via MD signature on the MFC Parent Certificate of Approval (see **Attachment V**);

- Review the on-going quality and appropriateness of MFC homes and services provided by individual MFC parents. Review and discuss with MFC staff their on-going recommendations of medical parents to continue in the MFC Program and provide written notification of the approval of medical parents annually via MD signature on the MFC MD Approval form and the MFC Environmental Review form;

- Provide corrective action plans for medical parents who have failed to respond to teaching assistance provided by the MFC staff and who remain out of compliance with MFC program standards. Corrective action plans are also appropriate when MFC parents' actions cause care concerns for the MFC child. Corrective action plans must be signed and dated by the MFC MD, and

- Determine if a medical foster parent should be withdrawn from the MFC Program. This determination usually occurs following the failure of a MFC parent to respond to teaching assistance and corrective action plans and who remain out of compliance with MFC program standards. It is appropriate to offer a meeting with the MFC parent to discuss this decision. Once the decision is final, a written notification of the decision to withdraw the parent from the MFC program must be signed and dated by the MFC MD and sent to the parent.

The MFC medical director's payment for services will be based on the area CMS' physician fee schedule.

Supervision of the MFC Program

The registered nurse supervisor will provide leadership and direction to MFC staff and ensure adherence to program standards and quality. Activities will include but not be limited to:

- Supervision of the MFC staff. The RN supervisor will provide support and technical assistance to MFC staff and will stay abreast of current program issues, staff workload, and staff performance such as time management and service provision;

- Coordinate and assure the orientation and on-going training of new and existing staff. See under "MFC Staff Orientation Requirements" in Chapter 3 for detailed staff orientation requirements. Ongoing training of MFC staff will include training to enhance the staff's ability to better serve this unique population;

- Provide support and technical assistance to MFC families. Answering phone calls, answering questions and considering input from parents that will enhance the program, meeting with MFC parents as requested, and receiving complaints and grievances are some of the activities associated with this role;

- Attend MFC staff meetings with the MFC MD, MFC RN, and MFC SW at least monthly to discuss the status of each MFC child. See under "MFC Staff Meetings" later in this chapter;

- Oversight of quality improvement in the MFC program to include record reviews and corrective action planning. The supervisor will conduct quarterly, and as needed, reviews of the medical, in-home, and administrative records, identify concerns, discuss with staff, and develop a corrective action plan. See Chapter 9 for specific information regarding this process, and

- Communication with the MFC consultants regarding local MFC Program issues and concerns, such as changes in program staff and organization, MFC parent issues, and MFC child placement and care issues. Requests for technical assistance, support, and sharing of ideas that may enhance the statewide program are welcomed.

Program Coordination and Timeframes in MFC

The MFC Program coordination activities may be performed by the MFC staff serving in the SW position, the RN position, the supervisor position, or another staff person designated by the MFC supervisor. In addition, these staff persons can share program coordination duties. Large MFC programs with more than 25 MFC homes function best with a full-time staff person assigned as the program coordinator. The program coordinator is responsible for ensuring that

MFC parents and homes meet MFC Program standards. Program coordination includes but is not limited to:

- Coordinate all administrative day-to-day operations of the MFC Program including referral conferences and staff meetings;

- Maintain the MFC administrative records for each MFC home. See Chapter 5 for record keeping requirements;

- Enter MFC data within five (5) calendar days of the activity being tracked and prepare reports as needed;

- In coordination with CBC, provide assistance in the recruitment of MFC parents such as referring prospective MFC parents to the CBC for foster parent pre-service training and receiving CBC referrals of licensed foster parents for MFC Parent Pre-Service Training;

- The MFC Program coordinator is responsible for all coordinating activities related to the screening of prospective MFC parents and the MFC Parent Pre-Service Training. Screening activities include a pre-training home visit and interview of the prospective parent. See **Attachment I** for Medical Foster Parent Training Procedures and Responsibilities;

- Assist parents with the Medicaid enrollment process, as needed. In addition, refer MFC parents to the appropriate Medicaid contract agent for provider training and assistance with the Medicaid billing process;

- The program coordinator may request previous prior authorization for MFC services;

- In coordination with CBC, provide assistance in the retention of MFC parents. The coordinator will obtain copies of annual and updated foster care licenses and license capacity waivers to ensure that MFC home capacities are not exceeded;

- Coordinate and track annual in-service MFC parent training. The MFC coordinator may refer parents to appropriate in-service trainings, approve in-service trainings that MFC parents have identified, or arrange for instructors to provide in-service trainings;

- Provide administrative support and guidance for medical foster families regarding Medicaid, CBC, and CMS requirements as they participate in the MFC Program;

- Ensure that the parent assessments are completed by the MFC RN and SW, annually, or as needed. See Chapter 8 for additional information on parent assessments;

- Assist the MFC parents in the development of an annual disaster plan and ensure it is kept up to date with MFC children in the home;

- Notify the local fire and rescue service of the status and location of MFC homes;

- Ensure and track fire drills done with the MFC family following a new MFC child admission;

- In coordination with the MFC RN, SW, and MD complete the annual and as needed medical home evaluations. See Chapter 8 for additional information on medical home evaluations;

- Ensure that teaching assistance and corrective action provided to MFC parents is documented in the administrative record;

- Act as the MFC Program liaison with other agencies, programs, and community providers such as hospitals, home health, schools, Medicaid, and CBC, and

- Assist the CMAT in educating other agency and program staff regarding the MFC Program and raising community awareness of MFC services. Networking in the community may include community meeting attendance, distribution of MFC information cards and posters, and placing advertisements.

Care Coordination and Timeframes in MFC

The role of the RN and SW care coordinator is that of pulling together all of the elements of each child's life related to his/her special care needs, in coordination with the primary care physician, specialists, community agencies, and the family. The care coordinator is a critical link in obtaining the appropriate medical and psychosocial interventions for the child within the context of their family, school and community and is integral for the development of a true medical home environment for the child and family. Care coordination includes but is not limited to:

Assessment and Care Planning

The RN and SW will provide ongoing assessment and care planning for the child and family. Interventions will address the child's medical, developmental, and psychosocial needs as part of a comprehensive plan of care. The care coordinator will analyze and modify the appropriateness of the interventions in the course of care coordination. See Chapter 8 in this plan for additional documentation requirements.

Assessment

- The RN will provide comprehensive nursing assessments to evaluate the child's medical, developmental, and safety issues. The nurse will conduct a face to face head-to-toe assessment of the child's health systems and take into account any current diagnoses. The RN will interview the child, if appropriate, caregivers, and providers to gather information. This information will include, at a minimum, the child's history, current health status, medications, treatments, equipment, activities of daily living, and

providers in order to provide a clear picture of the child's holistic care needs. Any changes in the child's health care needs must be communicated by the MFC parent to the RN within 24 hours of the change. This information gathering must be done prior to the child's MFC admission, as needed, and reevaluated during each home or community visit.

- The SW will provide comprehensive psychosocial assessments to evaluate the child, the MFC family, and the birth family. This activity will entail observation of the child and interview of the child (if appropriate) and of the MFC family, the family of origin, the CBC case worker, and any other persons involved with the child who have pertinent psychosocial information. The child's behavioral history and current functioning must be considered to include emotional stability and adaptation to the new home setting. Assessment of the MFC family must include family dynamics that impact the child, family makeup, parental employment, sleeping arrangements, and family interactions. Assessment of the birth family must include family makeup, legal issues, parental employment and psychosocial factors that may impact the child such as housing, health, and behavioral issues. A psychosocial assessment must be completed as comprehensively as possible prior to the child's admission into MFC, although it may take up to 30 days from the MFC admission date to complete all of the interviews necessary to complete the initial comprehensive psychosocial assessment. Following admission, changes in the child's circumstances must be assessed such as when the child is hospitalized or transferred to another home setting to include temporary transfers, progressive visitation for reunification and following discharge from MFC, to assess the child's adaptation to the placement disruption. Updates to the psychosocial assessments must be made as needed and following each home or community visit.

Care Planning

- The RN will provide comprehensive care planning to address the child's medical, developmental, and safety issues that were identified during the assessment. This activity entails communication with providers and caregivers, referrals to new providers, coordination of new services, and discontinuation of services that are no longer needed. This is an on ongoing process that is performed as the child's needs are identified.

  Specific nursing tasks may include but not be limited to arranging and referring for physical, developmental and behavioral screening, assessments, and interventions for children. Emotional support will be provided as needed to MFC children and families. Consultative services will be provided to medical parents, birth parents or relatives, DOH staff, AHCA staff, schools, community agencies, and DCF or CBC staff as necessary. The RN may accompany children, as necessary, to clinics for the purpose of sharing information with health care providers and coordinate follow-up services.

  The SW will provide comprehensive care planning to address the child's psychosocial issues that were identified during the assessment. This activity entails communication with the children, providers and caregivers. Referrals to new providers, coordination of new services, monitoring the child's psychosocial status when behavioral and family issues are identified, psychosocial support and advocacy and discontinuation of services

that are no longer needed are examples of SW interventions. This is an on ongoing process that is performed as the child's needs are identified.

Specific social work tasks may include but not be limited to arranging and referring for psychosocial screening, assessments, and interventions for children as well as referring MFC and birth parents to community resources. Emotional support will be provided as needed to MFC children and families. Consultative services will be provided to medical parents, birth and adoptive parents or relatives, DOH staff, AHCA staff, schools, community agencies, and DCF or CBC staff as necessary. The SW may accompany children, as necessary, to clinics for the purpose of sharing information with health care providers and coordinate follow-up services.

Home and Community Visits

The MFC RN and SW will visit the children's medical foster homes, birth homes, schools, clinics, hospitals and other environments where the children routinely spend time. Initial RN home visits must occur within 24 hours of placement, except when the RN was present during the MFC child's discharge from the hospital. In this latter case, the MFC RN must visit the child in the MFC home within 72 hours of placement. The initial SW home visits must occur within seven (7) calendar days of placement. Subsequent home and community visits should occur, at a minimum, every three months, and other visits should be based on each child's condition or the medical parent's need for the RN or SW to visit the home. It is expected that the RN and SW will see the medical foster children during each visit to their medical foster homes. If that is not possible due to the child's attendance at school, the staff can arrange to visit the child in the school setting. Following a child's discharge from MFC, the MFC RN and SW will visit the child in their new setting within seven (7) calendar days of the child's discharge date. Activities during the visit will include but not be limited to:

- RN and SW assessment of the child to monitor for improvement or deterioration in health, developmental and psychosocial status;

- RN and SW will discuss with the child's MFC parents, birth parents, teachers, CBC case worker, physicians, therapists, and other involved persons regarding the child's current issues and progress. Depending on the child's age and condition, include the child in this discussion;

- RN and SW will provide child-specific information and education regarding the MFC child's health and psychosocial issues to persons with a need to know;

- RN will review all in-home records each time they are in the foster home. Record keeping done in the home will be in accordance with record keeping requirements listed in Chapter 8 of this plan;

- RN and SW will observe the condition of the medical home during each home visit and report findings to the MFC program coordinator. See Chapter 7 of this plan for MFC home requirements;

- RN and SW will note when a MFC parent is out of compliance with MFC Program standards. This should be discussed with the parent to address the issue(s) and identify problem resolution. This teaching assistance facilitates good communication and clarifies program standards. All teaching assistance requires follow up. See Chapter 6 of this plan for instruction regarding teaching assistance and corrective action planning, and

- RN will review the child-specific training of MFC parents and other caregivers in the home and observe parents and substitute caregivers providing treatments and other care as ordered for each medical foster child. This will verify their competencies in caring for the child and will indicate whether further training is required. Before a caregiver can care for a MFC child, this RN verification of child-specific training must occur.

Reunification Activities - Working with Birth and Adoptive Families

- RN, with input from the SW, will provide written information within 30 days of MFC admission to the child's foster care case worker so that they will have the current psychosocial, safety, and medical information for the child's case plan and to present for court reviews. **This information should include what a caregiver will need to know to care for the child**;

- Child-specific training of the future caregivers of the child identified in the child's permanency plan is the responsibility of the MFC parent. The RN will make the necessary arrangements to ensure and verify completion of child-specific training to the child's parent, relative, adoptive parent, and other caregivers prior to reunification or adoption. The SW will attempt to develop a relationship with the child's future caregivers to assess their needs and strengths, provide necessary referrals to them and to provide support and encouragement to them in their efforts to receive the child into their custody;

- RN and SW will encourage the MFC parent to meet with and develop a working relationship with the future caregivers. If the MFC parent is comfortable with the idea, encourage visitation and child-specific training of the child's future caregivers to occur in the MFC home. This will offer the optimum environment for the child's future caregivers to learn how to provide medications, treatments and personal care to their medically complex or fragile child. It will also increase their comfort level regarding caring for their child in their own home and foster a successful reunification. The RN will provide this training if it is not possible for the MFC parent to provide it;

- RN and SW will participate with the child's foster care case worker in providing testimony and input to the court as requested, regarding the medical and psychosocial needs of the child to include the child's current progress, and

- RN and SW will assist in facilitating the permanency goal for each child and provide education and support to birth families, relatives, adoptive parents and other caregivers prior to reunification or adoption.

Collaborative Team Meetings

MFC Staff Meetings

The MFC MD, supervisor, RN, and SW will meet at least monthly to discuss the status of each MFC child. For each child, these meetings should occur prior to MFC placement when possible, while the child is in MFC, and at least once following discharge. The purpose of these meetings is to review the child's current medical, developmental, and psychosocial status and discuss recommendations from team members on how best to resolve problems and achieve goals. When possible, if the RN or SW is unable to attend this meeting, the supervisor should be briefed in advance of the meeting on all relevant issues to be discussed and shall delegate or present these issues for the absent staff member. If the MD is unable to attend the regularly scheduled monthly meeting, they may delegate to another MD or the meeting must be rescheduled during the month.

CMAT Staff Meetings

See under "Communication and Coordination with CMAT" earlier in this chapter.

Other Collaborative Meetings

As needed, the MFC MD, supervisor, RN and SW may together or separately attend meetings to discuss local area policies and procedures with other community agencies that could impact the MFC Program and to advocate on behalf of MFC children and families.

Transition and Discharge Planning

Transition and discharge planning should begin as soon as the child enters the MFC Program. Both the CBC and MFC staff will be involved in transition activities and discharge planning. Discharge is appropriate when a medical foster child's condition has improved to the point where the child no longer meets the medical eligibility for placement in the program, when MFC is no longer the most appropriate service or when CBC staff removes the child. See Chapter 8 for documentation requirements.

Transition for Discharge

Prior to discharge, arrangements will be made with the MFC parents, the child's foster care case worker, other service providers and the new caregivers. This coordination will allow planning for smooth transitioning of the child to their next setting. The following activities will be completed:

- It is recommended that the new caregivers be given an opportunity to visit in the medical foster home prior to the child's placement to learn from the medical foster parent about the care needs of the child;

- The medical foster parent will teach the new caregivers about the care needs of the child. At times, the training period involved in the transition of a child from the MFC program may take several weeks, depending upon the child's care concerns, number of progressive visitations for the child, the caregiver's ability, and environmental preparation of the new home. In order for the MFC parent to bill Medicaid for providing MFC services to their child during transition visits lasting 24 or more hours, the MFC parent must call the child's caregiver where the child is having their transition visit on a daily basis to check on the child. They must then document the nature of the discussion and the status of the child. If no contact is established, such as having to leave a message, the MFC parent may not bill Medicaid for that day. Reimbursement for these dates of service may not exceed 15 days during any 90-day period (unless an exception is granted from the Medicaid Area Office);

- The MFC RN will provide observation and evaluation of the ability of the new caregivers to provide for the medical, development and psychosocial needs of the child. This is documented on the MFC Child-specific Training Verification form (see **Attachment IV**). If possible, an evaluation of the new caregiver's home is recommended. A copy of these evaluations will be forwarded to the CBC case worker responsible for the child's case plan;

- The MFC staff will be available to the new caregivers during the transition period. While it is anticipated that a child who has been discharged from the program will no longer have serious medical complexities, it is expected that the new caregivers can benefit from knowledge about the child's previous complexities and medical history;

- Notification to the CMAT of an anticipated discharge from MFC within the next 30 days so that a CMAT staffing can be held prior to the MFC discharge is required. The purpose of this staffing is to identify and coordinate services in the child's new environment. This is documented on the MFC Medical Director's Recommendation form;

- If the new home is located outside of the MFC service area, arrangements will be made for the MFC staff in the receiving area to provide a home visit and assist the new caregivers with needed services until a CMS care coordinator is assigned to the child;

- Referral of eligible children to CMS for RN and SW care coordination. For out-of-state discharges, referral to other comparable nursing care coordination agencies will be made. Communication and coordination with the new care coordinators prior to MFC discharge is highly recommended for continuity of care, and

- Provision of a written discharge summary to be provided to the CBC case worker responsible for the child's case plan. This summary will include information on the child's current medical status, resources likely to be needed in the future and the care-giving skills that the child requires at the time of discharge.

Reasons for Discharge

Children may be discharged from the MFC Program when any one of the following occurs:

- The CMAT has determined and documented that the medical needs that brought the child into MFC have changed and, as a result of this, MFC is no longer the recommended service. For children remaining in traditional foster care following MFC discharge, it is preferable for the child to remain in the MFC home;

- The MFC Program can no longer meet the child's needs;

- The child has specific medical needs that require prolonged hospitalization, or is in need of specialized care, which the home is unable to provide;

- The MFC MD has determined that the welfare of other children or family members in the medical home is being jeopardized by the presence of the child in the home;

- When the MFC MD has determined that all goals identified in the plan of care have been accomplished and there appears to no longer be a medical necessity, a referral to CMAT is required to confirm that the child does not meet a MFC level of reimbursement;

- There are no appropriate medical foster homes available to meet the child's needs;

- The CBC has executed a permanency plan for the child other than the medical foster home in which the child resides, or

- The CBC has coordinated the adoption of the child by the MFC parent(s). In these cases, the pre-adoptive MFC parent will sign a memorandum of agreement for adoption and the subsidy agreement for the adoption subsidy. The child is still considered to be in legal foster care status, until the judge signs the final order of adoption. Until the final order is signed, the MFC parent can continue to provide and bill for MFC services, as long as the child is eligible for MFC.

In all instances above the CMAT must be notified.

Permanency Options

The permanency options available to the child, in order of desirability are:

- Reunification with the birth family;

- Adoption;

- Permanent guardianship;

- Permanent placement with a fit and willing relative, or
- Placement in another planned permanent living arrangement.

Discharge Procedure

Arrangements for discharge will be made with the MFC parents, the child's foster care case worker, other service providers and the new caregivers. The following activities will be completed:

- When the child is discharged from MFC, notification will be made to the CMAT, CBC case worker and the area Medicaid RNS. This is documented on the MFC Medical Director's Recommendation form;
- At the time of discharge, all current medical orders in the child's medical record will be copied to go with the child;
- The MFC RN and SW will offer to the new caregivers to visit their home during the week following discharge to assist with adaptation to the new placement and assist the family with needed services;
- Following MFC discharge, MFC staff should provide care coordination, to include an assessment of the child, family and home, to ensure the child's safety and adjustment for no longer than 30 days following discharge, until a CMS care coordinator is assigned. The MFC nurse will contact the receiving CMS care coordinator and provide a brief report to include any information the CMS care coordinator may need in order to provide an effortless transition. If more than 30 days of MFC follow up care coordination is indicated, the CMS nursing director will be advised of the situation and if approved, an exception is to be requested by the local area MFC staff to the MFC statewide consultants on a case by case basis. If the parent declines follow up services by MFC, document all attempts and close the case to MFC. If the parent declines CMS services, notify the CMS office of the parent's desire to discontinue CMS services;
- If the new home is located outside of the MFC service area, MFC staff in the receiving area will offer the follow up MFC home visit and provide care coordination until a CMS care coordinator is assigned, and
- MFC staff will retrieve the in-home record within seven (7) calendar days for record closure

Unplanned Discharge

Unplanned discharges of dependent children may occur when the court has ordered the child to be returned to their family or when the health and safety of a child or family member in the medical home might be endangered by the child's continued presence in the home. Children that are voluntarily placed by their birth parents may be discharged when their parents request

it. All discharges must be coordinated with the CBC. The following will apply for all emergency or unplanned discharges:

- If an unanticipated discharge occurs, notification will be made to the Medicaid RNS and to the CMAT so that a CMAT staffing can be held after discharge to ensure that the child's needs are being met in the new setting. This is documented on the MFC Medical Director's Recommendation form;

- In coordination with the CBC, the MFC Program will arrange for transfer of any child out of a medical foster home in which, in the professional judgment of the MFC MD and staff, the child's general health or medical condition may be compromised. The CBC has final placement authority for all foster children, and

- In addition to these exceptions, unplanned discharges will be followed by the regular discharge procedures noted above.

Death of a MFC Child

When a child death occurs in MFC, the following procedural steps will be taken:

- MFC parents must notify the CBC case worker and the MFC RN immediately following a child's death;

- When MFC staff are notified of a child death, they will immediately attempt to provide physical and emotional support in the field to the medical foster family during this time of family crisis;

- MFC staff will provide educational and emotional support to the child's birth family and make any necessary referrals;

- MFC staff will serve as liaison to the CBC case worker and to other providers, as necessary;

- MFC staff will notify the MFC consultants at CMS Central Office of the death and related issues by telephone or encrypted e-mail by the next business day. If the death occurs in a MFC contract program, the program must also notify the local CMS nursing director and comply with any associated requests;

- The MFC staff will notify the area CMAT;

- The MFC parent will document the details regarding the child's death in the in-home record;

- The MFC staff will retrieve the in-home record within 24 hours of the death. If the record has been removed from the home by investigators or any other personnel, request a copy of the record from them;

- MFC staff will request copies of all final medical records and documents to include hospital, autopsy and investigative reports;

- The MFC staff will meet with the MFC MD to review the records and discuss and review the events surrounding the child's care, death and any outstanding issues related to the child's medical foster parent and home. This written summary is to be sent to the MFC RN consultant and filed locally in a confidential file, and

- If requested by CMS Central Office, a copy of the child's in-home record, the previous 12 months of the child's medical record, the MFC parent's administrative record and the summary from the MFC staff meeting must be sent to the MFC RN consultant. The purpose of this activity is to determine if the MFC standards were met by all parties involved and to determine if quality care was provided to the child.

The CBC, or the child's birth family who have maintained legal rights to their child, have the right to make decisions regarding the child's funeral arrangements. If the medical foster family and staff are excluded from the service, it is suggested that the foster family with MFC staff support, arrange their own way to celebrate the child's life and recognize the death.

See Chapter 8 for documentation requirements, record handling, and retention procedures for closed MFC records.

Chapter 5 RELATED SERVICE DELIVERY SUBJECTS

On-Call Work in MFC

There will be one registered nurse on-call 24 hours a day, seven days a week available to the MFC parents as they care for medical foster children and to receive after-hour referrals to MFC. The after-hours on-call staff may be rotated among the CMS nursing director, the MFC nursing supervisor and the MFC nurse(s). The decision to allow other CMS RN staff to participate in the MFC after-hours on-call will be the CMS nursing director's.

MFC staff will be responsible for providing a written up-to date on-call schedule and the telephone numbers for on-call services to all MFC parents and to the DCF or CBC foster care staff who work with the MFC Program.

For DOH career service employees, all on-call services should be provided in compliance with the State of Florida, Division of Administration, Personnel Policies, On-Call Fees for Career Service Employees, DOHP-60-18-13.

All nurses taking call must:

- Have on-call duties clearly defined in a current position description. The MFC supervisor will review on-call responsibilities as stated in the position description;

- Be available via telephone or a designated electronic signaling device and remain available in the MFC Program area in order to work during the agreed-upon off duty period;

- Be familiar with the MFC Program and up to date on each of the MFC child's identified needs and plan of care and the caregiver's ability to provide care. It is also required that all persons who have on-call responsibility must participate in the regularly scheduled meetings with the MFC MD and staff. They must also know how to access the local DCF or CBC staff for after-hours emergency situations;

- Prior to assuming on-call responsibility, the on-call nurse must receive updated information on each child's medical needs to include the latest changes to the plan of care, the child's primary care provider, current medications and treatments, home location and phone numbers. It is recommended that this updated information be placed in an "on-call book";

- Have possession of the on-call book during on-call duty;

- Any instruction given to the family, information shared by the family, and child outcomes should be carefully documented in the child's medical record;

- All services provided while on call must be documented in a call log book with the date, time, name of the MFC parent, and the name of the MFC child. This log is subject to supervisory review, verification and approval and must be maintained in each MFC office for two years. Examples of on-call situations include, but are not limited to:

    - Consult with MFC parents regarding care issues when they arise after hours;
    - Consult with MFC parents to determine when emergency room visits are necessary;
    - Consult with CPI, CBC, and MFC staff regarding after-hour referrals and urgent placement requests;
    - Arrange for private duty nursing for a MFC child if the need arises on weekends and holidays and on business days after 5:00 p.m. and before 8:00 a.m.;
    - Coordinate with the CBC the transfer of children because of an emergency in the MFC home;
    - Intervene with medical staff or any other staff in the emergency room when the medical parent is having difficulty obtaining services for the child;
    - Support a MFC parent following a traumatic event, such as resuscitation of a child; and
    - Respond to the needs of the medical parent and the birth parent in the event of a child's death.

The RN who has been given an on-call assignment and is unavailable or does not return to work when called, shall not receive payment for the on-call period and may be subject to disciplinary action.

Additional Services for the Medical Foster Child

A medical foster child may have additional medical and developmental needs that cannot be met by the medical foster parent. When this occurs, the child's needs that are identified in the plan of care may be met by including other services. The use of other Medicaid professional health care providers and services must be related to the medical needs of the child and cannot be strictly for the convenience of the medical foster parent. Medically and developmentally necessary support services include:

Private Duty Nursing

Private duty nursing (PDN) and personal care may be incorporated into the child's plan of care. MFC parents are responsible for the overall parental care of the children assigned to them. The use of PDN and personal care services by home health agencies in the MFC home is intended to meet the child's medical needs which cannot be met by the medical foster parent. Examples of situations that may need to be addressed by the use of PDN in the MFC setting include:

- When a child's medical condition requires an awake caregiver at night to provide continuous or frequent intervention or observation (usually limited to 8 hours per night);

- When a child requires an intervention that is too complex to be provided by the medical foster parent (i.e. IV drug administrations or other procedures requiring a licensed practitioner), and

- Other situations, when medically necessary and appropriate.

PDN and personal care must receive prior approval from Medicaid's contracted prior authorization entity and meet the requirements of the Medicaid Home Health Services Coverage and Limitation Handbook.

Prescribed Pediatric Extended Care

Prescribed Pediatric Extended Care (PPEC) centers provide up to 12 hours of daily nursing intervention and medical supervision to children with special health care needs age birth to 21. PPEC's are state licensed and regulated and are operated and staffed by registered nurses, licensed practical nurses and other qualified personnel such as paramedics and nursing assistants with a ratio of one caregiver for three children. Services may be reimbursed by Medicaid in addition to MFC if the PPEC services are medically necessary and cannot be met by a MFC provider. The use of PPEC services in the MFC Program should be limited to meet specific goals.

PPEC centers must meet the requirement of the Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitation Handbook.

Project Aids Care

Children with AIDS may receive services from the Medicaid AIDS Home and Community Based Waiver, Project AIDS Care (PAC). Children who are receiving PAC services may also receive MFC services with the exception of PAC specialized personal care for foster children. Medicaid cannot reimburse both MFC personal care and PAC specialized personal care for the same foster child on the same date of service. Medicaid can reimburse other PAC services in addition to MFC.

The child's legal guardian or the young adult (if age 18 or older) must be given the opportunity to select the service that is most appropriate for the child. The MFC SW, foster care case worker and the PAC Program case manager will coordinate in assisting the child's legal guardian or the young adult in making the choice that is in the best interest of the young person and ensuring that there is no duplication of services.

PAC services must meet the requirements of the Medicaid PAC Waiver Services Coverage and Limitations Handbook.

Partners in Care: Together for Kids

Partners in Care: Together for Kids (PIC) is a pediatric palliative care program for children, ages 0-21 whom the primary care physician has certified and determined are eligible for the program, have a potentially life limiting condition, and are not expected to live past 21 years of age. PIC is a partnership between AHCA, CMS, and Florida Hospices and Palliative Care. PIC services include pain and symptom management, therapeutic counseling, expressive therapies for young children (music, art, and play), respite, hospice nursing, specialized personal care, and bereavement counseling. Services will be determined and agreed upon by the MFC team, the palliative care provider, and CMS care coordinator for PIC at the time of initial assessment and development of the PIC Initial Plan of Care. Service needs will be re-assessed every 90 days by this same team. MFC children may utilize all program services and must utilize at least two (2) PIC services to be enrolled in the program.

The child's primary care physician must approve PIC services on the CMS medical authorization form and the MFC RN must refer the child to the PIC coordinator at the local CMS office.

MFC parents can sign for consent to receive palliative care services. MFC parents can continue to bill for MFC services on those days that PIC respite is provided, however, if more than 24 hours of palliative respite services are provided, the MFC parent may not file a claim for MFC services during that same period.

Enrollment in the PIC Program does not replace the oversight and coordination responsibility of the MFC Program. PIC Program services are services that are provided in addition to services that are being provided through the CMS Network and the MFC Program. PIC is a payer of last resort and does not reimburse services already paid for by Medicaid.

Brain and Spinal Cord Injury Program

Children's Medical Services BSCIP serves children and youth from birth through age 18 years who sustain a moderate to severe brain and/or spinal cord injury. Florida law requires that hospitals and other providers report traumatic brain and spinal cord injuries to the BSCIP Central Registry. The BSCIP then refers the client to a CMS nurse care coordinator in the area where the client lives or is hospitalized. The program provides care coordination, therapy, rehabilitation services, home modifications, and other services to help clients remain in their homes, continue with education or vocational goals, and reach their best possible outcome in recovery from a brain or spinal cord injury.

Enrollment in the BSCIP does not replace the oversight and coordination responsibility of the MFC Program. BSCIP services are provided in addition to services that are being provided through CMS and the MFC Program. BSCIP is a payer of last resort and does not reimburse services already paid for by Medicaid.

Agency for Persons with Disabilities

The Agency for Persons with Disabilities (APD) is the state agency specifically tasked with serving the needs of Floridians with developmental disabilities. APD works in partnership with local communities and private providers to assist children and adults who have developmental disabilities and their families. APD also provides assistance in identifying the needs of people with developmental disabilities for supports and services.

Eligibility

A person must live in Florida, be at least three years old, and have a developmental disability that occurred before the age of 18 to be eligible for APD services. Children ages three to five who are at risk of being diagnosed with a developmental disability may also be served by APD. APD may provide a free assessment to determine if someone is eligible for services. Pursuant to Chapter 393 of the Florida Statutes, the term “developmental disability” is defined as “…a disorder or syndrome that is attributable to (mental) retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.”

Waiver Programs and Services

APD customers may be served in their community by funding provided through several waiver programs. Other customers are provided assistance without being enrolled in a waiver program. Services may include occupational and physical therapy, nursing, mental health counseling, personal care assistance, transportation, companion, behavior therapy, in-home support, adult dental services, and respite care. MFC contracted programs that bill for Targeted Case Management (TCM) may not bill for TCM for those children enrolled in the APD Waiver Support Program.

Residential Services

There are a number of different residential options available for Floridians with developmental disabilities. The four types of homes (which APD licenses) are defined within Section 393.063 of Florida Statutes as follows:

- "Foster care facility" means a residential facility which provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of its residents. The capacity of such a facility shall not be more than three residents.

- "Group home facility" means a residential facility which provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of its residents. The capacity of such a facility shall be at least 4 but not more than 15 residents.

- "Residential habilitation center" means a community residential facility that provides residential habilitation. The capacity of such a facility shall not be fewer than nine residents.

- "Comprehensive transitional education program" means a group of jointly operating centers or units, the collective purpose of which is to provide a sequential series of educational care, training, treatment, habilitation, and rehabilitation services to persons who have developmental disabilities and who have severe or moderate maladaptive behaviors. All such services shall be temporary in nature and delivered in a structured residential setting.

Applying for Services

An individual who has or might have a developmental disability or their authorized representative may apply for services at any time by contacting the APD office in their area. The supports and services for persons with developmental disabilities are provided through 14 APD area offices around the state. For more information regarding APD programs and services, please visit the agency's website at apdcares.org

Family Support Workers

Children's Medical Services has Family Support Workers (FSW) who provide family-to-family support and serve as family advocates to families who have children with special needs. Referrals to a FSW and their services include, but are not limited to, family requests for family-to-family support, family inquiries about community resources, and assisting CMS enrollees and their families participate in decision-making. A referral to the FSW at the local CMS area office may be indicated during progressive reunification visits as this will provide continuity to the birth or adoptive family as their child transitions from MFC to regular CMS services and a new care coordination nurse.

Alternative Caregivers

Alternative caregivers temporarily replace the care rendered by an assigned MFC parent to the medical foster child in their care, depending on individual situations. The purpose of using an alternative caregiver is to provide a means of meeting the medical needs of a child in MFC when the assigned medical foster parent is unable to meet the care needs of the child for a short time.

Situations which may require the use of an alternative caregiver include but are not limited to:

- Medical condition or illness of the child's medical foster parent that temporarily limits or prevents the parent from providing the medically necessary care to the child;

- Medical foster parent family illness;

- Medical foster parent training, and

- Temporary relief.

Types of Alternative Caregivers

1. Babysitters: All MFC parents must have an identified baby-sitter to provide backup and support. MFC baby-sitters must adhere to more stringent requirements than traditional foster care baby-sitters. The assigned MFC babysitter must be at least 18 years old, selected by the foster parent to care for their foster children, approved by the MFC RN, and must have received child-specific training with documentation of MFC RN verification. The baby-sitter must meet the CBC's background screening requirements in order to care for a MFC child overnight in the baby-sitter's home.

2. Another MFC Parent: The MFC parent must notify MFC staff prior to an unplanned temporary transfer of a MFC child to another MFC home.

3. PDN: A private duty nurse or home health aide may supplement and/or replace the medical foster parent's medical care of the child as a last resort. The private duty nurse may not replace the parenting responsibilities of the medical foster parent. When private duty nursing is to be used as a form of alternative care, a MD order is required with specific information of the child's needs which justifies this service and must be provided to the home health agency.

Temporary Relief for MFC Parents' Respite Needs – Overnight Stays

- Some MFC parents periodically need time for personal rest from medical care-giving. MFC parents may request respite from caring for MFC children for up to twelve (12) days each calendar year, which does not have to run consecutively. However, it is important to recognize that frequent placement disruption is potentially traumatic for children, so less frequent disruptions are desirable.

    - A newly-placed MFC child should be well established in the home before being transferred out to reduce the child's stress.
    - A minimum stabilization period of three months is recommended.
    - Additionally, all cognitively-intact MFC children in the home should be treated the same in regards to respite to avoid powerful resentments and self-esteem issues for those children not included in family vacations.

  If additional time is required greater than the 12 days, the MFC parent must work with the foster placement agency and the MFC staff on a case by case basis.

- Medicaid does not pay for respite. Only another MFC parent baby-sitter may bill Medicaid for providing MFC services while the child is in their care. Medicaid will not reimburse the assigned MFC parent and the temporary MFC parent for providing care to a child on the same date of service.

- Respite care is specifically for the parent's rest and does not include emergencies such as parent or immediate family illness or death or foster care-related training attendance.

- For planned temporary transfers to another MFC home, MFC parents are required to request respite days from the MFC team as far in advance of the respite dates as possible, with no less than two (2) weeks in advance notice. The MFC team will request placement authority from the CBC in all cases. The MFC staff will obtain MFC MD Recommendation of placement prior to obtaining CBC placement authority and request Medicaid prior authorization.

- Every attempt should be made to use the same temporary caregiver for each child for all respite care provided to reduce the child's anxiety.

- It is the responsibility of the MFC parent to provide child-specific training and ensure that the temporary caregiver is provided adequate medication, medical and other supplies to meet the total needs of the MFC child for the duration of the respite care. It is the responsibility of the MFC RN to provide verification of child-specific training to all temporary caregivers. The child's in-home record and any other relevant information necessary to care for the MFC child should also be given to the temporary caregiver.

- Following respite, MFC parent observations of deterioration in the child's physical health and emotional or behavioral status, such as regressive behaviors, clinginess, more frequent acting out or hyperactivity, negative changes in eating or sleeping behaviors and changes in bowel or bladder habits must be reported to the MFC team. Such symptoms usually indicate that the child is not emotionally resilient enough to tolerate placement disruptions well, and this should be taken into consideration to limit future respite requests.

- MFC families are encouraged to vacation with children in the MFC Program.

Hospitalization of MFC Children

- It is expected that MFC parents will visit and attend to their MFC child during the child's hospital admission to provide parenting and emotional support;

- The MFC RN and SW will provide support to the MFC family and child, track the child's progress, and update assessment information;

- Medicaid may reimburse the MFC parent for up to 15 days, during any 90-day period, when the child is absent from the MFC home due to hospitalization. The 15 days do not have to be consecutive. The Medicaid field office manager may make exceptions to this policy on a case-by-case basis. A written request for an exception, MFC MD statement, and supporting documentation must be provided to the Medicaid field office manager or an approved designee for an exception to this policy. Documentation in the in-home record of MFC parent contact with the MFC child and the child's status is required, in order for the parent to bill for MFC services during the child's hospitalization, and

- If the MFC child's care needs have changed which could affect the LOR determination at the time of hospital discharge, the MFC staff must refer the child to the CMAT for an emergency staffing.

IV Drug Administration / Procedures in the MFC Home

As a rule, MFC parents are not to perform intravenous (IV) procedures or administer IV drugs. MFC staff must coordinate with Medicaid to obtain home health nursing visits/nursing services to perform medical necessary IV drug administrations or procedures.

In rare instances, if private duty nursing services are not available for MFC children requiring IV antibiotics, continuous Total Parenteral Nutrition feedings, or central line dressing changes, the MFC Medical Director may grant an exception to this policy. All exceptions to this policy must be documented in the child's record and include the following: the procedure that has been approved, the duration of the procedure, and all associated training activities provided to the MFC parent. All exceptions to this policy must be time limited and in writing with the MFC Medical Director's signature.

Medical foster care parents providing medically-related services under this exception must be a licensed registered nurse who has successfully completed the necessary child-specific care training required to provide this care. MFC staff must verify through the Department of Health Medical Quality Assurance that the nurse holds a clear and active Florida license and place a copy of the current license in the Administrative Record. Each home providing medically-related services under an exception must be closely monitored by the MFC nurse who will visit the MFC home weekly during the first month of administration of IV care and complete the MFC Child-specific Training Verification form. Thereafter, the MFC nurse will visit the home at least monthly for the duration of the scheduled administration.

Communicable Disease

Communicable diseases arise in every community and with every population; therefore, MFC children stand the chance of being exposed. If any child in the MFC home is diagnosed with a communicable disease, it is the responsibility of the MFC nurse to obtain all pertinent information from the child's primary care physician and/or hospital and provide this information to the MFC MD. The MFC team will contact the county health department for reportable conditions and, if necessary, the Centers for Disease Control and Prevention for advisement on how best to control the spread of the disease. If necessary, the team will also obtain any recommendations regarding isolation or movement of the affected child. The CBC must be notified of the situation and any measures taken to control the communicability of the disease.

Normalcy

Normalcy refers to making a foster child's life as "non-foster-like" as possible, allowing the child to attend slumber parties, field trips, camps, etc.

For a MFC child who is planning to stay overnight outside the MFC home, the MFC parent is to provide child-specific training on the total care needs of the child to the adult caregiver who will be supervising the children during the slumber party and rule out any environmental concerns related to the child's condition. The MFC RN will provide verification of the child-specific training.

For MFC children attending field trips or non-medical camps, a responsible adult caregiver must be identified to receive child-specific training and the MFC RN will provide verification of the training. If the non-medical camp is out of the child's home area, courtesy child-specific training of the responsible adult caregiver at the camp and RN verification of that training may be provided by the MFC RN in that area. This will be a collaborative effort between the MFC parent and the sending and receiving MFC teams.

Transportation of MFC Children

- Only a medical professional or a caregiver who has been approved by the CBC and received child-specific training and been verified for this training by the MFC RN can transport a MFC child. Please see under "Transportation Safety" in Chapter 7;

- The CBC will reimburse MFC parents for transportation of a MFC child for family visitation, and

- The CBC will reimburse MFC parents at their current mileage rates for transportation to medical appointments required by a MFC child's care plan.

Child Transfers within MFC

Once a child has been placed in a medical foster home, it is recommended that the child not be moved from one home to another unless one of the following applies:

- The medical foster parent requests the child's removal, and collaborative attempts to address issues have been made;

- It is deemed to be in the child's best interest medically as recommended by the MFC MD, or

- The child is removed by DCF or CBC staff for reasons identified to the MFC parents and MD.

When it is necessary to move a child from a medical foster home, the child should be given every opportunity for appropriate transitioning, which includes visits to the new home and casework services designed to minimize the trauma of the move.

All child transfers within MFC must be recommended by the MFC MD. Permission from DCF or CBC must be obtained before any foster child can be placed in a new setting. Medicaid prior authorization is required for all MFC transfers. The CMAT must be notified of all MFC transfers.

Transfers within the Local MFC Area

When it is determined that a child will transfer from one MFC home to another within the service area, the following will occur:

- The MFC RN will communicate and coordinate transfer of all equipment needs, if necessary, to assure that all home and equipment specifications have been met;
- The MFC RN will set up a new in-home record for the new MFC parent;
- The MFC parent will provide child-specific training and deliver the child's medications, equipment, and possessions to the new parent;
- The MFC RN will have a face to face meeting with the new MFC parent and verify the child-specific training within 24 hours;
- The MFC RN and SW will make a home visit to the child within the new setting within seven (7) calendar days of the transfer to assess the child and family;
- MFC staff will retrieve the previous parent's in-home record within seven (7) calendar days for record closure, and
- The above activities will be documented in the current CMS-approved medical record.

Transfers outside the Local MFC Area

When it is determined that a child will transfer from one MFC home to another MFC home outside of the current service area, the following will occur:

- The sending and receiving MFC RN's and SW's will communicate and coordinate the out of area transfer. This will involve sharing of information such as the assessment and plan of care, ensuring that the sending and receiving CBC's have authorized the transfer, designation of the transportation provider and who will provide child-specific training of the new MFC parent;
- The sending and receiving MFC RN's will communicate and coordinate transfer of all equipment needs, if necessary, to assure that all home and equipment specifications have been met;
- The MFC child must be accompanied by a child-specifically trained caregiver during transport to the new location. This individual will be selected based upon the care needs of the child and the caregiver's ability to effectively deal with emergency situations which may arise during transport. The transportation of the child to the new location is reimbursable from the Medicaid transportation contract provider;

- The receiving MFC RN will set up a new in-home record for the new MFC parent;

- The new MFC parent will receive child-specific training from the caregiver that accompanied the child to the new location. If this is not possible, the receiving MFC RN will coordinate and ensure the child-specific training of the new MFC parent. The new MFC parent will also receive the child's medications, equipment, if applicable, and possessions;

- The receiving MFC RN will make a home visit within 24 hours to assess the child and family and verify the child-specific training;

- The receiving MFC SW will make a home visit within seven (7) calendar days to assess the child and family;

- The sending MFC RN and SW will follow up within seven (7) calendar days with the receiving MFC RN and SW to ensure that the child's needs and transfer of information and documentation requirements have been met;

- The sending MFC staff will retrieve the previous parent's in-home record within seven (7) calendar days for record closure, and

- The above activities will be documented in the current CMS-approved medical record.

When the Entire MFC Family Moves with their MFC Children

At times, the CBC will give a MFC family permission to move to a new location in the state with their MFC children. The sending and receiving MFC RN's, SW's, and program coordinators will communicate and coordinate this out of area transfer. This will involve sharing of information such as the assessment and plan of care, ensuring that the sending and receiving CBC's have authorized the transfer and communication with the sending and receiving licensing authorities. The following procedures will apply:

- The sending and receiving MFC RNs will communicate and coordinate transfer of all equipment needs, if necessary, to assure that all home and equipment specifications have been met;

- For sending MFC programs that are **located in a CMS office**, they must transfer the hard copy administrative record to the receiving CMS office;

- For sending contract MFC programs that are **not housed in a CMS office**, they must copy pertinent documents from the hard copy administrative record and fax or mail them to the receiving MFC program staff. The receiving MFC staff must set up a new administrative record;

- The in-home record will transfer with the MFC parent in the new location;

- The receiving MFC RN will make a home visit within 24 hours to assess the child and family;

- The receiving MFC SW will make a home visit within seven (7) calendar days to assess the child and family;

- The sending MFC RN and SW will follow up within seven (7) calendar days with the receiving MFC RN and SW to ensure that the child's needs and transfer of information and documentation requirements have been met;

- The above activities will be documented in the current CMS-approved medical record, and

- As soon as the DCF or CBC has approved an amended license for the new home, the MFC program coordinator must conduct a home evaluation, obtain MFC MD Approval of the parent at their new address and obtain a new prior authorization number at the new address before the parent can bill Medicaid for MFC services provided. This activity will be documented in the parent's administrative record.

Chapter 6 MFC PARENTS

Definition

An MFC parent is a foster parent who has been licensed to provide traditional foster care by DCF, has met all Medicaid requirements for the MFC Program, been approved by the MFC MD, and is a Medicaid provider of MFC services. All MFC parents must comply with the current Medicaid MFC Coverage and Limitations Handbook, the MFC Program standards as set forth in the MFC Operational Plan, and with the DCF and CBC requirements to remain eligible to provide MFC services. MFC parents are responsible for protecting the health information of medical foster children from unauthorized modification, destruction or disclosure and for safeguarding sensitive and confidential information. The Rights and Responsibilities of MFC Parents are outlined in **Attachment VI** of this plan.

Recruitment of MFC Parents

The MFC program coordinator is responsible for recruitment activities. These activities will be coordinated with the CBC licensing staff. Recruitment will not be limited to existing licensed foster homes but will include activities directed at publicizing the need for MFC parents in the community. Recruitment activities include but are not limited to:

- Attending a DCF-approved parent preparation training course “guest night” and sharing about MFC;
- Distributing brochures in the community in various locations, particularly medical facilities;
- Displaying MFC posters in public places;
- Distributing information for public service announcements such as radio, television and newspapers;
- Purchasing billboard announcements;
- Submitting special interest newspaper articles and help wanted ads, and
- Community networking and announcements at community meetings.

Selection and Approval of MFC Parents

The MFC Program staff will accept referrals and inquiries from all individuals interested in becoming MFC parents. The following activities will occur:

Screening of Prospective MFC Parents

A prospective parent must:

- Provide a copy of their certificate of completion from a DCF-approved parent preparation training course provided by the CBC;

- Provide a copy of their high school diploma or a general education diploma (GED). Exceptions to this requirement may be made by the MFC MD, with CBC approval, when the prospective MFC parent has demonstrated adequate literacy skills in English to enable them to read and understand written instructions regarding medical care and complete written documentation required by the program. See the following bullet for this competency-testing tool, and

- Complete a written questionnaire filled out by the prospective medical parent that addresses general information, lists family members, their dates of birth, parent education and experience, health-related training and references. This is to be documented on the MFC Prospective Parent Profile form (see **Attachment VII**).

Upon receipt of the information listed above, the MFC Program staff must:

- Conduct a home visit to determine if the home meets the medical home criteria established in this plan (see Chapter 7). During this home visit, MFC staff will conduct at least one interview with each person seeking to become a MFC parent in order to establish if the parent will be a good fit for this program. A narrative summary of the interview will be documented and must include at a minimum:

    - Educational background of the medical foster parent;

    - Previous experience in fostering children and in caring for medically complex children, and

    - Why they are interested in becoming MFC parents.

- They will also evaluate the home to address smoking, utilities, architectural barriers in caring for medically complex children, cleanliness of the household, adequate space for medical equipment and supplies and pets which may present a hazard to health and home safety.

MFC Parent Pre-Service Training

After a successful screening, prospective MFC parents may be referred to the MFC Parent Pre-Service Training anywhere in the state. Regional instructors approved by CMS Central Office staff must conduct this training. This course addresses the medical and parenting aspects of caring for medically complex children. This course includes instruction on:

- Growth and development of medically complex children;
- Procedures and techniques required to provide care to medically complex children;
- Observation and assessment of medically complex children;
- Management of diet and environment for medically complex children;
- Documentation of care provided according to CMS and Medicaid requirements;
- Parenting skills for medically complex children, and
- Permanency planning for medically complex children.

If the parent successfully completes this training, they will receive a "32-Hour Professional Parent Series: Medical Foster Parenting Certificate of Completion". These certificates will be provided to the area office by the CMS Central Office MFC consultant. The MFC Parent Pre-service training is completed once in a MFC parent's lifetime and does not have to be repeated.

All scheduled MFC pre-service trainings will be broadcast by the CMS Central Office MFC consultant to all MFC programs via a statewide e-mail and posted on the CMS Share Point site.

The local MFC staff may schedule a pre-service training in their area. Please refer to "Medical Foster Parent Training Procedures and Responsibilities" for detailed instruction on setting up a class (see **Attachment I)**.

Other Pre-Approval Requirements

- Request and review a copy of the most recent family self-study and the licensing study completed by a CBC family foster home licensing counselor;
- Request and review the home health inspection report made by the County Health Department or the DCF or CBC licensing specialist;
- Current documentation of training in Infant, Adult and Child Cardio-Pulmonary Resuscitation (CPR). CPR training must be provided by a live instructor, rather than an on-line course;
- Current documentation of training in Universal First Aid. First Aid training must be provided by a live instructor, rather than an on-line course;
- It is recommended that other adults in the home receive the same CPR and First Aid training;
- Documentation of the initial vaccination of the Hepatitis B immunization series or a recent (less than a year old) Hepatitis B post-titer lab report and a statement from their

physician for all adults in the home. Adults may choose to sign a waiver declining the immunization series;

- All adults in the MFC home must have an initial tuberculosis (TB) risk screening to determine if there are any TB risk factors (see **Attachment VIII**). This paper risk screening will be completed by the MFC RN based on an interview with the adult being screened. All screened adults must sign off on this form. All individuals that are shown to be at risk for TB based on this initial screening must provide documentation of a current medical evaluation from their healthcare provider regarding their medical status;

- DOH Information and Security training and HIPAA Privacy Practices Awareness training. MFC-specific information security training must be provided by MFC staff and should cover the maintenance of confidential information in written, oral and electronic form as it relates to the care of MFC children. Parents and the MFC coordinator must initial and sign off on the Acceptable Use and Confidentiality Agreement (see **Attachment IX**);

- Copy of the DCF or CBC Family Foster Home traditional license*, and

- Local fire and rescue services must be notified in writing of all homes planning to become medical foster homes.

All of the above pre-approval documents should be placed in a temporary file prior to MFC MD Approval.

*NOTE: It is not a DCF or CMS requirement that the traditional foster parent license be amended to reflect “Medical Foster Care” in order for the home to be approved for placement of MFC children.

MFC MD Approval of MFC Parents

MFC staff will meet with the MFC MD to discuss the approval of prospective MFC parents. This discussion will include a review of all pre-approval documentation and the staff’s concerns and recommendations. If all requirements have been satisfactorily met, the MFC MD will sign the Medical Foster Parent Certificate of Approval (see **Attachment V**). The MFC program coordinator will forward a copy of the Medical Foster Parent Certificate of Approval to the family foster home licensing counselor that conducted the licensing study and issued the foster home license. MFC children can be recommended to the MFC home following this approval. See under “Annual and On Going MFC Parent Requirements” later in this chapter for information on annual MD re-approval of parents.

Medicaid MFC Provider Enrollment

Following the MD Approval, MFC parents must enroll to become a Medicaid provider of MFC services. The MFC program coordinator will assist MFC parents in this process. The following documents must be sent electronically to Medicaid Enrollment Services:

- Medicaid Provider Enrollment Application for MFC services;
- Copy of the Family Foster Home License;
- 40-Hour Professional Parent Series: Medical Foster Parenting Certificate of Completion, and
- Medical Foster Parent Certificate of Medical Director Approval.

MFC parents must follow Medicaid Enrollment Services' instructions regarding finger printing requirements. Before a MFC parent provides MFC services, they are required to contact their local Area Medicaid Office and speak to the Medicaid RNS or the provider trainer in their area to request the following required provider training:

- Medicaid's MFC Provider Training on Medicaid Claims Submission and Billing.

Once the MFC parent receives their Medicaid provider number, they may bill Medicaid for reimbursement for MFC services provided. MFC children placed in the home following MD Approval but before the Medicaid provider number is assigned, may bill Medicaid retroactively. The date that Medicaid Enrollment Services received the provider application, is the date that retroactive billing may begin. Medicaid Enrollment will provide this date in an e-mail to whoever submitted the electronic enrollment form.

To be eligible for Medicaid billing, all MFC parents must follow the Medicaid provider requirements as outlined in the MFC Services Coverage and Limitations Handbook and the Florida Medicaid Provider General Handbook. See, "Obtaining Medicaid Prior Authorization" in Chapter 4.

Annual and On-Going MFC Parent Requirements

The MFC program coordinator is responsible for assisting parents and coordinating the following annual and on-going requirements:

- Twelve (12) hours of in-service training annually related to the care of medically complex foster children. MFC parents are responsible for obtaining the required training and communicating their training issues with the MFC staff. The MFC staff must approve each in-service training topic. In-service training activities approved to meet this requirement may also be applied to meet the in-service training requirement for foster home re-licensing. These annual 12 hours must be documented on the MFC Annual Parent In-Service Training Log (see **Attachment X**) and will include the following:
    - A minimum of two (2) hours of MFC Policy and Procedures Update training which will include the current Information Security training and the HIPAA Privacy Practices Awareness training that DOH provides. MFC-specific security training must be provided by MFC staff;

- A minimum of eight (8) hours of training that is medical in nature related to the care of medically complex children. These hours may include no more than two (2) hours for Infant, Adult, and Child CPR and Universal First Aid training combined. Training in CPR and First Aid must be provided by a live instructor and remain current at all times, and

- A maximum of two (2) hours of training that is psychosocial in nature related to the care of foster children. Parents are encouraged to receive more than two hours for their benefit but, it cannot be counted towards the MFC in-service requirement.

- A satisfactory MFC Parent Skills Assessment by the MFC RN and SW of the MFC parent's ability to provide care to MFC children. This written evaluation should address how the medical parent provides for the health, developmental and psychosocial needs required of the children in their care. This evaluation must also address the compliance of the MFC parent with MFC Program standards, including communication, documentation, record keeping and adherence to confidentiality policies. This evaluation may be conducted at any time that the MFC staff deem appropriate but is required at least annually. Annual evaluations need to be completed within three months prior to the MFC MD's annual re-approval of the MFC parent. Examples of instances when an evaluation is indicated may include changes in the foster family structure or illness of a foster family member which may impact the caregiver's ability as a medical foster parent. (See **Attachment XI**). A copy of the MFC Parent Skills Assessment is provided to the medical foster parent;

- A satisfactory MFC Environmental Review by the MFC staff of the medical foster home. Documentation of this evaluation is required annually and as needed. Annual evaluations need to be completed within three months prior to the MFC MD's annual re-approval of the MFC home. (See **Attachment XII**). A copy of the MFC Environmental Review is provided to the medical foster parent. See under "General Home Requirements" in Chapter 7 for specific requirements;

- All adults in the MFC home will have an annual TB risk screening to determine if there has been any change in their TB risk factors (see **Attachment VIII**). Subsequent annual TB risk screens are self-reported and the adults should complete the form themselves and sign it. The MFC RN is also required to sign off on this completed form. All individuals that are shown to be at risk for TB based on this annual screening must provide documentation of a current medical evaluation from their healthcare provider regarding their medical status;

- For all adults in the MFC home who did not choose to sign a waiver declining the Hepatitis B immunization, completion of the Hepatitis B immunization series is required within one year of the MFC parent's initial MFC MD Approval;

- Documentation of a comprehensive disaster preparedness plan updated annually and kept current with MFC children in the home (see **Attachment XIII**); See "Disaster Plans and Preparation" in Chapter 8 for specific requirements;

- Documentation on the MFC Fire Drill Log of fire drills conducted with the family within seven (7) calendar days of new MFC child admissions (see **Attachment XIV**). See under "Fire Drills" in Chapter 7 for specific requirements;

- A current valid license as a family foster home issued by DCF or CBC;

- A current active MFC Medicaid provider number; and

- Medical Foster Parent Certificate of Approval is required annually (see **Attachment V**). The MFC staff will meet with the MFC MD and submit the above documents as a package for review and approval. When approved, the MFC program coordinator will forward a copy of the Medical Foster Parent Certificate of Approval to the family foster home licensing counselor that conducted the licensing study and issued the foster home license and to the medical foster parent.

  Annual MD Approval of MFC parents will occur on one of the following approval dates, which are due on either:

  - April 1, or
  - October 1.

  See under "Technical Assistance and Corrective Action Plans" and "Reporting to AHCA, Bureau of Medicaid Services" later in this chapter for specific information for working with parents who do not obtain and submit their annual requirements prior to their renewal date.

  When a new MFC parent joins an area MFC Program, the MFC program coordinator will notify them of their MD re-approval date. This first re-approval may occur sooner than 12 months but may not exceed 12 months.

Secondary Employment of MFC Parents

MFC parents can maintain other employment while caring for MFC children and billing for MFC services, however, the child's care needs must be met at all times. Stay-at-home care givers are required for MFC children. Unless it is for the specific therapeutic benefit for the MFC child, day care and after school care settings are not appropriate for MFC children.

Supervision of MFC parents

Supervision of services delivered by MFC parents must be provided by the area MFC Program staff in accordance with the child's plan of care and the MFC Statewide Operational Plan. The MFC Program Coordinator takes lead on the supervision of the MFC parents' administrative requirements. The MFC RN takes lead on the supervision of the MFC parents' medical care of MFC children. The MFC SW takes lead on the supervision of the MFC parents' psychosocial care of MFC children. The MFC supervisor provides oversight to this supervision and the MFC MD provides medical direction for the MFC Program.

Teaching Assistance and Corrective Action Plans

When MFC staff identify that a medical foster parent is not following MFC operating procedures as outlined in the current MFC Statewide Operational Plan and the MFC Services Coverage and Limitations Handbook, MFC staff must provide teaching assistance and, if necessary, corrective action to the medical foster parent. All teaching assistance and corrective action provided must identify the deficiencies, provide instructions to the parent for correction of the deficiencies, identify the timeframe in which the deficiencies are to be corrected by the parent and followed up on by the MFC staff.

Teaching Assistance

- Teaching assistance provided to MFC parents by MFC staff is an informal and ongoing process during the course of service provision. Teaching assistance enhances good communication and quality services provided to the child and can be accomplished face to face or over the phone with the MFC parent. All teaching assistance must be followed up on by the MFC staff to determine if the identified deficiencies were corrected.

- All teaching assistance with the due date for staff follow-up, associated activities and the outcome of these actions must be documented. All issues related to teaching assistance that impacts the parent will be documented in the administrative record for the purposes of tracking only. It is the care coordinator's professional discretion to document appropriate child-related issues regarding teaching assistance and its impact on the child in the child's medical record.

Corrective Action Plans

If the provision of teaching assistance does not bring the medical parent into compliance by the follow-up date, the following formal corrective action planning process is required:

- A corrective action plan requires written notification to the MFC parent documenting the identified deficiencies, previous teaching assistance provided, the exact instructions provided to the parent to correct the deficiencies, and the date that MFC staff will provide a follow-up review to determine if the deficiencies were corrected. All corrective action plans must be signed and dated by the MFC MD;

- MFC staff must review the corrective action plan with the medical foster parent and request that the medical foster parent sign a statement on the corrective action plan that they reviewed the plan. If staff has documented care concerns on the corrective action plan, the medical foster home should be visited more frequently than usual and the findings of the visits must be documented. MFC staff are responsible for reviewing the outcome of the corrective action with the medical foster parent by the date specified on the plan;

- All corrective action plans, associated activities and the outcome of these actions must be documented. It is the care coordinator's professional discretion to document appropriate child-related issues regarding corrective action and its impact on the child in the child's medical record. All issues related to corrective action that impacts the parent will be documented in the administrative record. All corrective action plans are to be filed only in the Administrative record;

- If the foster parent does not meet the annual minimum MFC Program requirements by the MFC MD Certificate of Approval renewal date, MFC staff will provide corrective action which must include notifying Medicaid. See "Reporting to Bureau of Medicaid Services" in the next section;

- If corrective actions do not bring the home into compliance with MFC and Medicaid standards within the timeframe identified, the Medical Foster Parent Certificate of Approval may be withdrawn or other appropriate action taken;

- In some cases in which the level of non-compliance of program standards is considered significant and may harm a child, a corrective action plan will be immediately implemented and copies provided to the medical foster parent, to the CBC licensing counselor and to the child's foster care counselor. In some cases, the MFC MD may recommend transferring a child out of a MFC home due to care concerns. These concerns must be communicated and coordinated with the child's foster care counselor. Permission from DCF or CBC must be obtained before any foster child can be placed in a new setting. See "Child Transfers Within MFC" in Chapter 4, and

- If neglect or abuse of a child is suspected, MFC staff must notify their supervisor, the child's foster care counselor, and the Florida Abuse Hotline at (800) 962-2873. A decision regarding continued placement of a medical foster child in the home under investigation for abuse, neglect or care concerns in relation to the medical foster parent must be coordinated with the CBC foster care unit and the MFC Program.

The CMS nursing director and contract program administrator, if applicable, and the MFC MD will provide technical assistance to staff regarding which issues can be addressed by teaching assistance, corrective action and/or abuse hotline methods.

Reporting to AHCA, Bureau of Medicaid Services

For foster parents who require a corrective action plan due to failure to meet their annual MFC Parent Requirements, corrective action must include the local area MFC staff reporting via e-mail to the MFC RN Consultant at AHCA, Bureau of Medicaid Services Headquarters and copying the MFC Consultants at CMS Central Office in Tallahassee. Medicaid Headquarters and CMS Central Office staff will follow up by contacting the MFC parent. Failure to meet the annual requirements within a prescribed timeframe may result in the pending of the Medicaid Provider number which will suspend Medicaid reimbursement. Decisions regarding Medicaid reimbursement issues will be made by Medicaid.

Withdrawal of the MFC MD Certificate of Approval

A medical foster parent has the right to withdraw from the MFC Program at any time. The MFC MD has the right and responsibility to withdraw the approval for medical foster parent participation based on:

- Noncompliance with DOH, DCF or AHCA policies and procedures related to the MFC Program;
- Noncompliance with DOH Information Security procedures and HIPAA policies, and
- Concerns related to the care of medical foster children in the home.

All withdrawals of approval must be supported by documentation in the MFC administrative records describing the concern(s). All withdrawal of approval notices must be copied and sent to the medical foster parent, the area Medicaid office, the MFC Liaison at Medicaid Headquarters' office, and the CBC licensing counselor and contain the following information:

- The noncompliance issues or care concerns regarding the medical foster parent;
- The effective date of the withdrawal of approval;
- The reason for the withdrawal of approval;
- A statement that the withdrawal of approval may not necessarily affect the parent's foster care license status, and
- The MFC MD's signature.

Disenrollment of MFC Parent Providers

Following withdrawal from the MFC Program, MFC parents are to send a signed letter with their name, Medicaid provider number and the date they withdrew from the MFC Program to the current Medicaid fiscal agent.

MFC staff must send a letter via e-mail attachment, which has been signed by the MFC MD with the parent's name, Medicaid provider number, the reason for withdrawal, the date of their withdrawal and the status of their MFC MD Approval to the current MFC Liaison at Medicaid Headquarters. If a letter is being sent to the MFC parent from the MFC MD (see previous section), a copy of that letter may be sent to Medicaid Headquarters as sufficient notification.

MFC Parent Complaints and Grievances

A complaint and grievance process should be offered to any MFC parent who expresses verbal or written expression of dissatisfaction regarding the administration or provision of services. The policy is as follows:

- For MFC non-contract programs, follow the CMSN Complaint and Grievance Policy and Procedure (**See Attachment XV)**;

- For MFC contract programs, the individual organizations complaint and grievance policy will be followed and the MFC Supervisor will notify the CMS Regional Nursing Director and Central Office MFC Consultants of the complaint. If the complaint is unable to be resolved within the organization, the complaint will pass on to the CMS Regional Management Team and thereafter, if the matter is unresolved, the CMS Network Statewide Grievance Committee, and

- For Medicaid provider issues involving eligibility or reimbursement, the provider must access the Florida Division of Administrative Hearings or the court system.

Foster Care Reimbursement to MFC Parents

Foster Care Board Rate

MFC parents receive foster care board rates for children and young adults in the MFC Program directly from the CBC. The CBC is required to provide medical foster parents no less than what traditional foster parents in the same area receive for foster children ages 13-21 years of age, regardless of the age of the MFC child. MFC parents may be offered a higher board rate than the highest traditional foster care board rate in the same area for recruitment purposes. Beginning in January 2015, this MFC board rate will receive at least the same percentage of cost of living increases as traditional foster parents on an annual basis.

Transportation

Transportation provided by MFC parents for medical appointments, special care, educational and vocational training, or visits to parents and relatives will be reimbursed by the CBC at the current CBC rate for mileage.

Respite

Respite care is defined as the temporary, intermittent care of a foster child by an individual other than the child's out-of-home caregiver. Respite funds may be available to MFC parents through the CBC for up to 12 days per year. Medicaid funding may not be used to provide a medical foster parent respite from caring for a child assigned to their care.

Liability

The Division of Risk Management of the Department of Financial Services (see s. 409.175, F.S.) will provide coverage through DCF to any person who operates a family foster home for DCF. The coverage provided under the Florida Casualty Insurance Risk Management Trust Fund is for general liability claims arising from the provision of family foster home care pursuant to an agreement with the department and based on guidelines established through policy, rule or statute. This general liability coverage does not prevent foster parents from obtaining additional coverage for their own purposes. Community based foster care providers under contract with DCF must maintain their own liability insurance (see s. 409.1671, F.S.). MFC parents licensed by DCF must report all liability issues to their district DCF or CBC office.

MFC Parents as Medicaid Providers

MFC parents who meet DCF foster care licensing requirements and have been approved by the MFC Program MD may enroll as Medicaid providers of MFC services. They may be reimbursed by Medicaid for medically necessary services rendered to children served by the MFC Program. As Medicaid providers, MFC parents have the following responsibilities:

- Participate in Medicaid's MFC provider training on Medicaid claims submission and billing;
- Meet all annual MFC requirements as outlined in "Annual and On Going MFC Parent Requirements" in this chapter;
- Meet all requirements set forth in the Florida MFC Services Coverage and Limitations Handbook;
- Provide full time care to MFC children. See Rights and Responsibilities of MFC parents (see **Attachment VI**);
- Document the services provided to the medical child;
- Complete their own electronic filing for Medicaid reimbursement and submit requests for reimbursement to the Medicaid fiscal agent, and
- Discuss with their tax accountant the federal income tax issues associated with the Medicaid reimbursement, if necessary.

Local MFC staff will provide technical assistance regarding parent Medicaid enrollment and reimbursement and will assist the parent with communication and coordination with the Medicaid fiscal agent as necessary. MFC providers or staff may contact their local Medicaid office if further assistance is needed.

Medicaid Reimbursement to Medical Parents

Medicaid will reimburse MFC parents according to the following:

- S5145 HA - Level I MFC Service - $38.80 per day
- S5145 TF - Level II MFC Service - $48.50 per day
- S5145 TG - Level III MFC Service - $67.90 per day

Chapter 7 MEDICAL FOSTER HOME REQUIREMENTS

Maintaining the Medical Foster Home and Premises

The medical foster parent will maintain the medical foster home and premises according to the criteria that follows. It is the responsibility of the program coordinator to document inspection of MFC homes when the RN or SW report environmental concerns and annually.

General Home Requirements

A medical foster home is a home that has met the licensing requirements of Chapter 65C-13, Florida Administrative Code and has been inspected by MFC staff and has been approved by the MFC Medical Director as a medical foster home. The following will apply to the medical foster home:

- Homes must not have architectural barriers that prevent the child's participation in normal situations. Ramps, doors, corridors, toileting and bathing facilities, furnishings and equipment must be designed to meet the medical and developmental needs of children;

- Homes must allow children safe and uninhibited access to move in and out and around the home and allow for thorough cleaning;

- There must be adequate lighting in the home to allow a person with normal or corrected vision to be able to read the plan of care, read dosages on prescriptions and to document care given;

- Homes must have air conditioning and vented heating;

- Cleanliness of households must be maintained so that there are no health risks for medically complex children;

- Antibacterial soap and paper towels must be available in the bathroom, and

- Pets in the home must be currently vaccinated in accordance with Chapter 65C-13.011, Florida Administrative Code and may not be in medical foster homes without the MFC MD's approval. When considering approval of pets in a MFC home, consideration must be given, but is not limited to the following:

    - The size of the animal (can the pet knock down and trample a child?);

    - The animal's general disposition (does the animal growl, scratch or snap at people in the home or behave aggressively at mealtime?);

- The type of animal (can the pet strangle a child? does the pet carry communicable disease to humans?), and

- The number of animals in a home.

Review and approval by the MFC MD of all pets in the home must be documented, approved and signed off by the MFC MD annually. Additional pets added to the home during the MFC MD Approval period must be documented, reviewed, and approved via signature by the MFC MD on an as-needed basis. When considering placement of individual MFC children in a home with pets, consideration must be given to the child's medical condition, the pet hair and dander that the child can cope with, as well as the size, types and number of pets in the home. Approval of pets in MFC homes will be at the discretion of the MFC MD.

Smoking

During the time medically complex children reside in the medical foster home, there will be no smoking in the house or in any vehicle that transports medical foster children. Prior to placement of medically complex children where one or more persons have smoked in the home, extensive cleaning will be completed prior to a child's placement. Extensive cleaning means a thorough cleaning of the home, which includes scrubbing walls, floors, windows, blinds and counter tops with a solution of 1:10 bleach to water; dry cleaning or washing all curtains or drapes; machine washing sheets and towels; machine washing or dry cleaning bed spreads and blankets and shampooing carpets & sofas. Consideration must be given to third-hand smoke on clothing when recommending the placement of some medically fragile children into a home in which someone is a smoker.

Utilities and Telephone Service

There must be working utility services and a telephone in the medical foster home at all times except for power outages related to the failure of the telephone or utility service. There must be no interruption of telephone, electricity or other utility service due to nonpayment of these services

Equipment and Supplies in the Home

All medications and medical supplies, which could cause injury to a child, must be kept in a locked container or cabinet.

Prior to placement of a child requiring medical equipment, MFC staff must call a representative from the durable medical equipment provider to address the safe use of electrical medical equipment placed in the home.

General Safety of Medical Foster Homes

Keeping medical foster homes safe is a part of providing direct services to a child in the MFC Program. It is the responsibility of the CBC licensing unit to ensure the general safety of foster homes. When in the home, MFC staff should observe each home as needed for the safety of medication storage, medical equipment, as well as fire, adequate home wiring, electrical hazards, water and/or pool hazards, pets, firearms, etc. Safety concerns must be addressed with the MFC parent. If these concerns cannot be immediately corrected, MFC staff must notify the CBC licensing counselor.

Waste

All outdoor garbage and other waste materials will be kept in covered containers until removed. Containers must be emptied as often as necessary to prevent public nuisance, health hazards and unsightliness, in accordance with all applicable state and local ordinances. The foster home must be kept free of unnecessary and unusable accumulations of possessions that constitute health or fire hazards.

Biomedical and Bio-Hazardous Waste

At times, the medical foster home may generate waste that is classified as “biomedical” or “bio-hazardous”. The MFC parent will dispose of this waste following OSHA standards, biomedical or bio-hazardous waste should not mix with the storage of common household waste. MFC staff will coordinate with the MFC parent in arranging for the storage and pick-up of biomedical and bio-hazardous waste in accordance with county and state ordinances.

Insect and Rodent Control

The medical foster home must be maintained free of infestation of insects and rodents. Consideration must be given for children who cannot tolerate insect and rodent insecticides and poisons as well as their accessibility to baits and traps in the home.

Fire Safety

Prior to foster home licensing, the home will be inspected and approved by the CBC licensing specialist, as required by DCF. This inspection includes fire prevention and environmental safety. If this inspection reveals safety concerns, the MFC coordinator should address corrective measures with the medical foster parent prior to placement of children.

Fire Drills

All foster parents must have a fire evacuation plan posted in a conspicuous place and must share the plan with each child and adult in the home as per DCF policy. Fire drills a minimum of two times per year must be conducted to ensure all persons in the home understand the evacuation procedure. These requirements will be tracked by the CBC licensing agency.

For MFC parents, it is also required that fire drills be conducted within seven calendar days of each new medical foster child admission. MFC staff will provide a blank log for parents to complete following each initial fire drill with all new MFC children. The entire family must be included in the fire drill. The log must include the date of the drill, initials of the family members involved and pertinent evacuation information. This initial fire drill log will be turned in to the MFC coordinator annually by the parent's MFC recertification date and should be filed in the administrative record. It is recommended that MFC staff visiting the home, ask the MFC parent about their initial fire drill following each new MFC child admission. Only initial fire drills with MFC children will be tracked by MFC staff (see **Attachment XIV**).

Notification to Local Fire and Rescue

The local entities responsible for fire and rescue services must be notified in writing of all homes planning to become medical foster homes and prior to the MFC MD's initial approval of the medical foster parent. Once the notification is sent, a copy will be maintained in the administrative record. Upon closure of the medical foster home, the MFC coordinator will send a notification of this change in the status of the home.

Some emergency management systems require child-specific information or registration for special consideration of the home. The MFC coordinator will assist the medical foster parent in this process, if necessary.

Disaster Plans and Preparations

It is critical that each medical foster family have a comprehensive plan that addresses the evacuation plan for all medical foster children in the home pending a disaster, like a hurricane or heavy smoke from a wildfire. The development of the disaster plan is the joint responsibility of the medical foster parent and the MFC coordinator. The following is required when developing a MFC disaster plan.

- All initial disaster plans must be completed prior to the initial approval of the home by the MFC MD using the MFC Disaster Preparedness Plan (see **Attachment XIII**). If pre-registration is required for the family's selection of a disaster shelter or special needs disaster shelter, the MFC coordinator is responsible for assisting the family with that process. It is the responsibility of the MFC coordinator to make certain that the plan is comprehensive and correctly completed by the medical foster parent prior to accepting the plan;

- The document should be readily available in the medical foster home in a central location. A copy will be maintained in the disaster plan file and should be centrally located in the area MFC office for easy accessibility by MFC staff;

- The plan must be updated to include each new medical foster child admission within 7 calendar days of the child's placement in the home. The medical foster parent and MFC coordinator must communicate and document a single matching evacuation destination for the new child on their respective copies of the disaster plan. Selecting an option to stay at home is not an appropriate evacuation destination, and

- The entire disaster plan will be reviewed and updated by the medical foster parent and the MFC coordinator at least annually.

In the event that an evacuation is recommended by emergency management for a pending disaster, MFC parents will proceed immediately with their medical foster children to the agreed-upon evacuation destination, or as soon as the designated special needs shelter is open if that is the evacuation plan, even if the evacuation is not required at that time. This is necessary due to the medical complexities of the children being evacuated and to avoid being caught for long periods in backed-up traffic. Prior registration may be required to use a special needs shelter, depending on the local county's policies, and this must be arranged in advance.

Transportation Safety

MFC parents must adhere to the following:

- Have transportation available 24 hours a day. All vehicles used to transport children must be in safe condition, in compliance with applicable motor vehicle laws of the state, equipped with seat belts and approved car seats for children under the age of four years and booster seats for children up to 75 pounds and must meet all transportation safety requirements. Additionally, no child under the age of 12 will ride in the front seat with air bags in place;

- All vehicles owned by MFC parents must have automobile insurance to include liability for transporting children. Insurance policies must be available for inspections by the CBC licensing counselor;

- No MFC child will be transported unless the driver of the vehicle holds a valid driver's license, and

- MFC parents must not transport foster children in truck beds, motorcycles or any other method of transportation which might be considered dangerous to the child.

Changes During the Licensed Year

If a medical foster family moves, the new home must be inspected by the CBC licensing staff and the MFC Program staff in order to be considered for foster care licensing and approval as a medical foster home. Once approved, the MFC Program must conduct an environmental evaluation and, if satisfactory, the MFC MD will determine approval of the home. A new MFC MD Certificate of Approval will be issued for the medical foster parent at the new address prior to continued placement of medical children in the home.

Chapter 8 RECORD KEEPING

Records Required by the Program

The MFC Program requires a child's medical record maintained by the MFC staff, a child's in-home record maintained by the medical foster parent and an administrative record for each medical foster home maintained by the MFC coordinator. Additional records include an initial parent training file and a centrally located disaster plan file, easily accessible by all MFC staff in the event of a disaster, which will be maintained by the MFC coordinator. Listed below are the specific requirements of each record:

Documentation shall be written or typed at or near the episode of care (within one business day). Please refer to HCMSP 145-101-13, CMS Documentation of Client Medical Records Policy for documentation timeframes and requirements.

Child's Medical Record

A medical record for each child will be maintained by the MFC Program and will be the official record of the child in which all program staff will document services delivered. The MFC RN has primary responsibility for the maintenance of this record.

Electronic component of the medical record: All MFC staff will document MFC staff assignment to the child's case, assessments, care plans and progress notes in the current CMS-approved documentation system which is considered the child's CMS medical record. Timely and accurate documentation in this format is important for quality assurance, tracking, and reporting purposes.

Until the new CMS electronic medical record becomes fully operationalized statewide, the following will apply: Hard copy component of the medical record: In CMS area offices, the MFC child's medical record is the child's CMS medical record. In contract MFC programs housed separately from CMS, this record is simply referred to as the child's medical record.

The entire medical record (both components) will be defined as a record that contains, at a minimum, the following documentation:

- Notes: The MFC RN, SW, supervisor, and on-call staff will document all contacts with the MFC child, providers, family members, schools, and other agency's staff regarding the child. Progress on the identified care plan tasks and expected outcomes, including reunification and adoption efforts and child/family visitations will be documented in the Notes section of the electronic medical record. Attendance at all meetings and hearings will be documented from a child-specific perspective in the Notes. Home visits must be briefly noted in the Notes with who was present and the update to the Assessment cross-referenced;

- Assessment: The MFC RN and SW will document history and observations of the MFC child gathered during contacts with the MFC child, providers, family members, schools, and other agency's staff regarding the child. The assessment must be kept up to date on an ongoing basis;

- Plan of Care: The MFC RN and SW will document medications, treatments, equipment, immunizations, and pertinent concerns and issues to the plan of care. Interventions and the expected goals from those interventions for each area of concern will be documented on the plan of care by the MFC RN and SW. The MFC MD will review and provide a signature of approval on the plan of care for each Medicaid prior authorization period. The plan of care must be kept up to date on an ongoing basis;

- Documentation of transition planning and coordination of services provided for the child prior to, during and following discharge from MFC;

- Copies of updated orders from physicians and other health care professionals;

- Copy of a current up-to-date growth chart;

- Copy of immunization records of required and recommended vaccinations received;

- Clinical transcriptions of clinic visits including summary of findings;

- Copy of the results of laboratory tests performed;

- Current CMAT assessment;

- Current CMAT staffing summary that identifies the Level of Reimbursement assigned;

- Current copy of the court order or voluntary placement agreement placing the child into shelter or foster care;

- Documentation of services provided by other agencies or providers;

- Current consent for medical treatment and release of information;

- Clinical notations made by medical personnel;

- Documentation of the child-specific training in the care of the child provided to foster or birth family members, relatives, adoptive parents, or any other person providing care to the child, using the MFC Child-specific Training Verification form (see **Attachment IV**);

- Copy of a summary provided to the child's CBC counselor regarding the skills and abilities any caregiver must acquire to safely care for the child in a home setting;

- All birth family or relative evaluations and reports written by MFC staff to foster care agencies or courts;

- Current copy of the child's dependency case plan or documentation that MFC staff have requested the latest case plan from the child's CBC counselor, and

- Copies of all correspondence related to the child.

Child's In-home Record

Each medical foster parent will keep an in-home record for each child in their care. This record is a legal medical record and should be taken by the medical parent with the child to all health care appointments. The child's in-home record must meet the Medicaid requirements listed in the current MFC Services Coverage and Limitations Handbook. The in-home record must be kept up to date and available to MFC staff at all times. Only MFC staff are permitted to remove documents or cull the in-home record.

The in-home record may not contain documents that name more than one medical foster child. All information in the child's in-home record, except court orders and case plans that may name siblings, must be exclusively related to that child. Each page of the in-home record will note the child's name and each entry will note the complete date and time, including a.m. or p.m. designation. Each child's in-home record must contain, at a minimum, the following:

Administrative Information:

- A listing of emergency telephone contacts and phone numbers to include at a minimum: on-call MFC staff, child's physician, hospital, child's foster care worker and/or supervisor, poison control and 911 for all emergencies using the MFC Emergency Contact Information form (see **Attachment XVI**);

- OPTIONAL FORM: A contact tracking log that includes a listing of all persons who have contacted the medical foster child or foster parent regarding the child including appointments, home visits, telephone calls, family visitation, etc., using the MFC Family / Agency Contact Log (see **Attachment XVII**). If the contact log is not used, this information must be documented in the progress notes;

- Documentation of the child's Medicaid eligibility, such as a copy of the Florida Medicaid Management Information Screen (FLMMIS), which can be requested from the Medicaid RNS, and

- Copies of Medicaid Prior Authorization Verification forms.

Medical Information:

- The child's current or updated plan of care;

- Copies of each new or revised medical order from physicians and other health care professionals, filed with the child's plan of care;

- The child's current CMAT assessment completed by the RN and SW;

- The child's current CMAT staffing summary with Level of Reimbursement assignment;

- Daily progress notations by the medical foster parent that include narrative documentation that notes the care the parent has provided in accordance with the treatment outlined in the plan of care, indicating the child's condition, psychosocial issues, and any other significant events in the child's day-to-day care. Detailed information must be included on outcomes from appointments, telephone or face to face contacts, and school meetings concerning the child. If these notes are typed, they must be signed off by the parent and filed in the in-home record daily. If these notes are handwritten, they will be documented on the MFC Progress Notes form (see **Attachment XVIII**);

- Documentation of teaching provided by the medical foster parent to the child's birth parents, relatives, baby-sitters, other foster parents, or other caregivers, and

- Detailed medication and treatment flow sheets documenting the administration of routine and as needed (PRN) medications and treatments by the parent. These flow sheets must include date the order started, date the order stopped, name of medication or treatment, how it is to be administered, how often, and what time the medication or treatment was administered. Any PRN medications or treatments given must include documentation as to the outcome of the drug or treatment. Caregivers are to initial each time they administer a medication or treatment. When initials are used, a signature block with full signature and sample of that individual's initials must appear on each page. The following flow sheets must match the plan of care with regard to the administration of medications and treatments:

    - Routine medication administration is to be documented using the MFC Medication Flow Sheet (see **Attachment XIX**);

    - PRN medication administration is to be documented using the MFC PRN Medication Flow Sheet on colored paper to help differentiate between the two flow sheets. Two versions of the MFC PRN Medication Flow Sheet are available depending on the usual frequency of PRN medication dosing for a particular MFC child (see **Attachments XX (1) and XX (2)**), and

    - Treatment administration is to be documented using the MFC Treatment Flow Sheet (see **Attachment XXI**).

  If a medication or treatment is provided by a private duty nurse, a school nurse, a birth parent or due to hospitalization, the MFC parent will note that with the appropriate legend in the appropriate time block(s).

Legal Information:

- A copy of the current court order or voluntary placement agreement placing the child into shelter or foster care;

- A copy of the current consent for medical treatment and release of information, and

- A copy of the child's current case plan.

Security of the In-Home Record

When a MFC parent is going out of town with their child or attending appointments, court, visitation, or meetings on behalf of the child, the MFC parent is expected to carry the In-home record to the visit in order to better provide accurate information on the status of the child. During such outings, the In-home record must remain with the MFC parent at all times to ensure security of the record in order to maintain confidentiality for the child.

When a MFC parent plans to be away from home with their MFC child for brief events such as, but not limited to, birthday parties and shopping, they may leave the In-home record at home in a secure location. If medications or treatments are expected to be administered while the parent is away from home, the MFC parent may place the child's MFC Plan of Care and Medication and Treatment Logs in a folder. The folder must remain with the MFC parent at all times to ensure security of the folder in order to maintain confidentiality for the child. In the case of an emergency, the parent must make arrangements to have the In-home record delivered to them, such as at the hospital, or call the MFC team for assistance in obtaining the record.

The In-home record and the folder containing the Care Plan, Medication Logs, and Treatment Logs should never be left unattended in a vehicle.

Administrative Record

The MFC Program administrative record for each medical foster home will be housed in the MFC office and maintained by the MFC coordinator. This record will document adherence to program standards by the MFC parent and data collection requirements. Child-specific medical and psychosocial notations may not be contained in the administrative record. This record must contain, at a minimum, the following:

- MFC Prospective Parent Profile is a self-report questionnaire completed by the prospective MFC parent. The purpose of the questionnaire is to gather demographic information and to determine if the foster parent can read, write, and comprehend the English language (see **Attachment VII**);

- An initial written assessment, based on a home visit and interview, of the prospective MFC parent and their family conducted by MFC staff. The purpose of the interview is to allow the MFC staff to get to know the foster parent and family. Topics should include foster parent life experiences, strengths, values, and concerns as well as information regarding their support systems, community involvements, and hobbies;

- Pertinent information from the CBC foster care licensing unit including the initial Family/Parent Profile from the foster parent's DCF-approved parent preparation training course provided by the CBC and their certificate of completion from that training, as well as their most recent licensing summary;

- Medical Foster Parenting Pre-Service Training Certificate of Completion;
- A copy of current Infant, Adult, and Child CPR certificate with expiration date;
- A copy of current First Aid training card with expiration date;
- A copy of documentation indicating current HIPAA Training;
- A copy of documentation indicating current DOH Information Security Training;
- The DOH Acceptable Use and Confidentiality Agreement form signed by the foster parent and MFC staff. This document is required to be completed only once, following the initial DOH Information Security Training (see **Attachment IX**);
- A copy of the current, valid family foster home license for the foster parent issued by DCF or CBC;
- Documentation of notification or registration with the local fire and rescue service;
- Documentation of Hepatitis B immunization or the signed declination of the vaccine for all adults in the home;
- Documentation of the initial TB and annual TB risk screening for all adults in the home (see **Attachment VIII**). Positive answers on the risk screening will require documentation of appropriate medical follow up on TB status such as a chest s-ray report or a letter of clearance from the person's physician;
- Current and previous Medical Foster Parent MD Approval form, signed and dated by the MFC MD (see **Attachment V**);
- Copy of the FMMIS printout indicating active Medicaid MFC parent provider status. A current copy must be filed with each Medicaid provider renewal period;
- An in-service training log that identifies the annual 12 hour requirement of in-service training completed by the parent (see **Attachment X**). The training log must include date, time spent in training, description of the training, and instructor. Back-up training certificates may be filed behind the training log. See Chapter 6 for a detailed description of this requirement;
- Annual and as needed home environmental assessment. The MFC MD's review and signature of approval and the signature of the person who assessed the home is required on this home environmental assessment. See Chapter 7 for a detailed description of this requirement. (See **Attachment XII** for a sample of an environmental review form. Use of this particular form is optional, however, the home standards to be reviewed as outlined in Chapter 7 of this plan must be documented, reviewed and signed by the person who reviewed the home and by the MFC MD.);

- Annual and as needed evaluation of the medical foster parent's care giving skills and overall performance of medical parenting duties. See Chapter 6 for a detailed description of this requirement. This evaluation must be dated and signed by the MFC RN and SW. The MFC parent is to be provided a copy of the evaluation. (See **Attachment XI** for a sample of a parent's skills assessment form. Use of this particular form is optional, however, the parent skills standards to be reviewed as outlined in Chapter 6 of this plan must be documented, reviewed, and signed by the MFC RN and SW.);

- An annual fire drill log. See Chapter 7 for a detailed description of this requirement (see **Attachment XIV**);

- MFC Medical Director Recommendation form (see **Attachment II**), signed and dated by the MFC MD recommending each medical foster child and all other children placed in the medical foster home, all medical foster child transfers within the MFC Program (both temporary and permanent transfers) and all medical foster child discharges from MFC;

- The MFC Child Placement Log, listing **ALL** children cared for in the home including medical foster children, non-medical foster children, birth children, adoptive children and minor relatives and friends. This log should reflect the dates that MFC parents bill Medicaid for their MFC children and should match the MFC data in the current CMS-approved documentation system (see **Attachment XXII**). This log must include:

    - Child's initials;
    - Child's date of birth;
    - Child's sex and race;
    - Child's medical or non-medical status;
    - Indication if foster home licensing age or capacity waiver required from the CBC;
    - Child's date of placement in the home, and
    - Child's date of physical removal from the home.

- Documentation of teaching assistance provided to the MFC parent and copies of all corrective action plans given to the parent for maintaining compliance with program standards. Instructions on teaching assistance and corrective action plans are provided in the Supervision of MFC parents section in Chapter 6;

- Notations of interactions, either in person or by telephone, or by other means between the medical foster parent, the DCF or CBC licensing staff, Medicaid staff, involved agencies and MFC staff regarding issues related to the home and MFC parent's provider status. This does not include child-specific information;

- A copy of all correspondence between the medical foster parent, the DCF or CBC licensing staff, Medicaid staff, involved agencies and MFC staff related to the home and provider status. This does not include child-specific correspondence, and

- A copy of all foster home license capacity waivers issued for the medical foster home by the DCF or CBC.

Pre-Service Medical Parent Training File

This file, maintained by the MFC coordinator, will contain documents procured from each State of Florida Medical Foster Parenting Pre-Service Training class held in that MFC program area. Each class represented in this file should contain daily student sign-in sheets, each student's completed Independent In-Class Assignments and a copy of each student's Medical Foster Parenting Training Certificate of Completion.

Disaster Plan File

This file, maintained by the MFC coordinator, will contain copies of the current and previous disaster plan for each medical foster home and should be centrally located for easy accessibility in the event of a disaster (see **Attachment XIII**). Instructions on required contents of disaster plans are provided in the Disaster Plans and Preparations section in Chapter 7.

When a medical foster home closes to the MFC Program, that family's final disaster plan will be stored in the closed administrative record.

DCF or CBC Foster Care and Licensing Records

The DCF or CBC records for each foster child and family will be kept in accordance with their program rules and procedures and monitored in accordance with DCF's standard monitoring practices.

Handling Records for Transfers and Discharges

Medical Records

Handling of Medical Record when a Child is Transferred

Until the CMS electronic medical record becomes fully operationalized statewide, the following will apply: When a MFC child is transferred from one MFC program to another, the child's hard copy CMS medical record is transferred to the CMS office in the new area for MFC programs housed in CMS area offices in accordance with the CMS Operational Policies and Procedures Handbook, Area Office Transfer Process.

CMS medical records are not to be transferred to contracted MFC programs that are not housed in CMS; rather, pertinent documents must be copied from them and sent to the receiving MFC program and the actual medical record sent to the receiving CMS office.

The medical record is the property of contract MFC programs housed separately from the CMS area office. Contract MFC programs housed separately from the CMS area office must copy pertinent documents from the child's medical record, send them to the receiving MFC program, and close, label and store the medical record. The closed medical record is to be accessible for 10 years. Retain all closed hard copy medical records for one (1) year. Following one year, they may be stored in either hard copy or electronic format for an additional nine (9) years. If stored in an electronic format, all scanned documents must be legible and each saved record must be accessible in their entirety. Once the hard copy record has been stored electronically, the hard copy record may be shredded.

Handling of Medical Record when a Child is Discharged

Until the CMS electronic medical record becomes fully operationalized statewide, the following will apply: When the child is discharged from MFC, the child's medical record will continue as the child's CMS medical record for MFC programs housed in CMS area offices. When the child is closed to CMS, the record will be stored in accordance with the DOH Record Retention Schedule for closed records.

The child's medical record is the property of contract MFC programs housed separately from the CMS area office. Contract MFC programs housed separately from the CMS area office will label and store the closed medical record. The closed medical record is to be accessible for 10 years. Retain all closed hard copy medical records for one (1) year. Following one year, they may be stored in either hard copy or electronic format for an additional nine (9) years. If stored in an electronic format, all scanned documents must be legible and each saved record must be accessible in their entirety. Once the hard copy record has been stored electronically, the hard copy record may be shredded.

In-Home Records

Handling of In-Home Record when a Child is Transferred

When a child is transferred from one MFC home to another MFC home, the in-home record should be immediately collected from the original medical foster parent by the MFC staff and copies of pertinent sections should be put into a new in-home record for the new medical foster parent. The original in-home record should be labeled and stored as a closed record. If the child transfers to another CMS area, the child's closed in-home record must be transferred to the new CMS office, in accordance with the CMS Operational Policies and Procedures Handbook, Area Office Transfer Process for MFC programs housed in CMS area offices.

The in-home record is the property of contract MFC programs housed separately from the CMS area office. Contract MFC programs housed separately from the CMS area office will label and store the closed in-home record. The closed in-home record is to be accessible for 10 years. Retain all closed hard copy in-home records for one (1) year. Following one year, they may be stored in either hard copy or electronic format for an additional nine (9) years. If stored in an electronic format, all scanned documents must be legible and each saved record must be accessible in their entirety. Once the hard copy record has been stored electronically, the hard copy record may be shredded.

Handling of In-Home Record when a Child is Discharged

When a child is discharged from the MFC Program, the child's in-home record should be removed from the MFC home within seven (7) days by the MFC staff. The in-home record should not be disassembled or combined with the medical record; rather, it should be left intact and properly labeled as the child's closed in-home record. Until the CMS electronic medical record becomes fully operationalized statewide, the following will apply: For MFC programs housed in CMS area offices, the in-home records will be merged with the closed medical record once the child is closed to CMS.

The In-home record is the property of contract MFC programs housed separately from the CMS area office. Contract MFC programs housed separately from the CMS area office will label and store the closed in-home record. The closed in-home record is to be accessible for 10 years. Retain all closed hard copy in-home records for one (1) year. Following one year, they may be stored in either hard copy or electronic format for an additional nine (9) years. If stored in an electronic format, all scanned documents must be legible and each saved record must be accessible in their entirety. Once the hard copy record has been stored electronically, the hard copy record may be shredded.

Administrative Records

Handling of Administrative Record when MFC Parent Transfers Out of Area

When a medical foster parent transfers from one area MFC program to another MFC program, the sending MFC program may copy pertinent documents from the administrative record such as CPR and First Aid Certificates, Hepatitis B and tuberculosis testing documents and the Medical Foster Parenting Pre-Service Training Certificate of Completion to the receiving MFC program.

The sending area's administrative record will then be closed, labeled, and stored in accordance with the DOH Record Retention Schedule for closed records when that program is housed in CMS.

The administrative record is the property of contract MFC programs housed separately from the CMS area office. Contract MFC programs housed separately from the CMS area office will

label and store the closed administrative record. The closed administrative record is to be accessible for 10 years. Retain all closed hard copy administrative records for one (1) year. Following one year, they may be stored in either hard copy or electronic format for an additional nine (9) years. If stored in an electronic format, all scanned documents must be legible and each saved record must be accessible in their entirety. Once the hard copy record has been stored electronically, the hard copy record may be shredded.

The sending MFC coordinator will ensure that the end date is entered in the MFC provider data. The receiving MFC coordinator will ensure that the medical foster parent is entered in the MFC provider data in the CMS-approved documentation system.

Handling of Administrative Record when MFC Parent Resigns

When a medical foster parent resigns from the MFC Program, the administrative record must be closed, labeled, and stored in accordance with the DOH Record Retention Schedule for closed records when that program is housed in CMS.

The administrative record is the property of contract MFC programs housed separately from the CMS area office. Contract MFC programs housed separately from the CMS area office will label and store the closed administrative record. The closed administrative record is to be accessible for 10 years. Retain all closed hard copy administrative records for one (1) year. Following one year, they may be stored in either hard copy or electronic format for an additional nine (9) years. If stored in an electronic format, all scanned documents must be legible and each saved record must be accessible in their entirety. Once the hard copy record has been stored electronically, the hard copy record may be shredded.

The MFC coordinator will notify the area Medicaid RNS of the resignation of the medical foster parent from the MFC Program and ensure that the end date is entered in the MFC provider data.

Use of Abbreviations and Acronyms in Documentation

MFC parents and staff may use approved abbreviations and acronyms only, as specified in the current DOH Clinical Abbreviations/Acronyms/Symbols Policy, DOHP 380-3-12.

Confidentiality, Retention, and Release of Medical Information

Confidentiality, retention and release of all medical information, whether verbal or written, must meet the requirements of all state and federal laws. All medical records are to be maintained and closed as required by the CMS Central Office and retained in accordance with the current DOH Confidentiality and Security, DOH Records Retention Policy and HIPAA policies.

Chapter 9 GOALS, OBJECTIVES, SUPPORT AND REVIEW

Data Requirements

The MFC Program coordinator or other designated staff will collect and enter MFC Program data. Data requirements for both CMS and contract MFC programs will be the same as stipulated by the CMS Central Office, the DCF Headquarters Office and the AHCA, Medicaid Program Development Office in a format provided by CMS Central Office. Data will be entered into the current CMS-approved documentation system. The current CMS-approved documentation system User Guide is available on the CMS SharePoint site at http://cms.sharepoint.doh.ad.state.fl.us/CMSN/CMSNPOL/qmu/Quality%20%20Practice%20Management/Forms/AllItems.aspx?RootFolder=%2fCMSN%2fCMSNPOL%2fqmu%2fQuality%20%20Practice%20Management%2fPolicies%2c%20Manuals%20and%20CAP%2fQI%20Plan&View=%7b3E0117B0%2d28C7%2d4F08%2d840E%2d45954B8DDFC9%7d and available upon request of the MFC consultants at CMS Central Office.

Medical Foster Care Data Requirements

The CMS Area Office is responsible for ensuring that child demographic data is entered into the current CMS approved data system. Often, MFC staff will gather the necessary information on new children to the program and provide the demographic information to the CMS staff person responsible for ensuring this data is entered.

MFC Provider Data

All MFC parent provider information is to be submitted to the CMS Central Office MFC Consultants by the Area Office MFC coordinator. The following MFC provider data is to be submitted to CMS Central Office:

- MFC parent's name;
- MFC parent's Medicaid provider number;
- MFC parent's street address;
- MFC parent's telephone number;
- Date of MFC parent's Medical Parenting Certificate of Completion (Date_Train);
- Date that MFC Medicaid provider number became effective (Date_Start);
- Date that first MFC child placed with this MFC parent (Date_Parent);
- Minority status of MFC parent (Yes=minority, No=not minority), and
- Date that MFC Medicaid provider number discontinued (Date_End).

Once the child's demographic information and the provider's demographic information has been entered into the current CMS-approved electronic systems, it will become available to view in the current CMS–approved electronic systems within approximately 24 hours. The MFC coordinator is responsible for the reliability and validity of this data.

MFC Child Data

The following MFC data will be collected on each medical foster child and entered within seven calendar days of the activity being tracked or as soon as is possible:

- Date child was initially referred to MFC (usually by the CMAT);
- Referring Level of Reimbursement, and
- Whether child was placed in MFC or not (yes or no).

If placed in MFC (yes):

- Date child was placed in MFC;
- Placement reason;
- Client origination (where child was residing prior to MFC placement);
- Date child discharged (when applicable), and
- Discharge destination.

If not placed in MFC (no):

- Reason not placed.

Additional MFC data that is to be entered for each child in the program includes:

- Names of all parent/providers assigned to the child;
- Child's level of reimbursement with each parent/provider;
- Start date of each level of reimbursement with each parent/provider;
- End date of each level of reimbursement or with each parent/provider;
- Inpatient hospitalizations and emergency room visits during each level of reimbursement with each parent/provider;
- Start date of inpatient hospitalizations and emergency room visits;
- End date of inpatient hospitalizations and emergency room visits, and
- Reason for inpatient hospitalizations and emergency room visits.

All transfers from one parent/provider to another within the statewide MFC Program, including temporary transfers are to be tracked in the MFC data.

Medical Foster Care Reports

In the current electronic reporting system, the following MFC reports are available:

- MFC Clients: Admitting dates (new clients) and Active dates (all clients). Enter the desired date range for either of these options and select one of the following reports to view and/or print:

- MFC Client List;
- MFC Clients by Diagnosis and Level of Reimbursement (care);
- MFC Clients by Diagnosis and Age Range;
- MFC Clients by Placement Reason;
- MFC Clients by Referring Level of Reimbursement (care);

- MFC Clients by Origination and Discharge Destinations, and
- MFC Clients Inpatient Hospitalization / ER Visit.

- Clients Referred to MFC but not Placed: Enter the desired date range to view and/or print this report;

- MFC Providers: Enter the desired date range to view and/or print this report, and

- MFC Providers and Clients: Enter the desired date range to view and/or print this report.

The MFC coordinator will view the reports for accuracy and ensure the correction of any errors. Accurate MFC data is a MFC performance standard and will be reviewed quarterly by the area office and annually by the CMS Central Office. Reports will be used for legislative planning, research and program development.

Quality Improvement Activities

MFC staff in the CMS Central Office will coordinate with the local area MFC teams to plan and implement on-going documentation reviews and other quality improvement activities to include those performed locally as well as validation monitoring and technical assistance visits conducted by the MFC consultants in CMS Central Office.

Area Office Responsibilities

Each area office is responsible for the following MFC quality improvement activities:

- Ensure that MFC parents are providing care to MFC children according to the current MFC Statewide Operational Plan and the plan of care on a day to day basis;

- Ensure that MFC staff are in compliance with their performance of duties as outlined in the current MFC Statewide Operational Plan, and

- Ensure that all MFC providers and MFC homes meet the provider and home requirements as identified in the current MFC Statewide Operational Plan.

Local quality improvement monitoring activities are the responsibility of each MFC team and will include, at a minimum:

- Quarterly review of the medical and in-home, and administrative records. This includes a review of the RN, SW and MD documentation and the MFC data component;

- Continuous Quality Improvement Plan (CQIP) will be developed for all standards below compliance.

These reviews will be documented on the current CMS Central Office MFC Quality Management Review Tools. All quality improvement activities will adhere to current instructions from CMS Central Office as referenced in the current CMS Network Quality Improvement Process Plan located on the CMS SharePoint site at http://cms.sharepoint.doh.ad.state.fl.us/CMSN/CMSNPOL/qmu/Quality%20%20Practice%20Management/Forms/AllItems.aspx?RootFolder=%2fCMSN%2fCMSNPOL%2fqmu%2fQuality%20%20Practice%20Management%2fPolicies%2c%20Manuals%20and%20CAP%2fQI%20Plan&View=%7b3E0117B0%2d28C7%2d4F08%2d840E%2d45954B8DDFC9%7d .

In addition, area staff will review the program's overall effectiveness in providing quality health care with supporting outcomes. When reviews completed by area staff indicate a need for technical assistance, the area staff will request assistance from other area MFC Programs, if appropriate, and from MFC staff at CMS Central Office.

Questions or problems regarding compliance with program standards for the MFC Program may be referred to the CMS Central Office, the DCF Headquarters Office, or AHCA, Medicaid Program Development.

CMS Central Office Responsibilities

Quality improvement activities performed by CMS Central Office staff to ensure compliance with the MFC Statewide Operational Plan and state and federal standards include validation of the area office's review findings and providing technical assistance when requested or indicated. Visits to the area office will be scheduled by CMS Central Office staff and in accordance with the current review schedule, or more frequently as deemed necessary by CMS Central Office. Staff required to participate will include the MFC RN consultant, the MFC SW consultant, and the statewide MFC physician consultant or their designees.

The statewide MFC physician consultant component of the visit will specifically address the medical components of each MFC Program and will include a review of the medical director's role and function, review of a limited number of children's medical records and an interview with the area MFC MD. This component of the review was designed to assure that each MFC Program has strong and available medical direction.

In addition to the RN and SW statewide MFC consultants, MFC RN and SW peer representation from other areas may be used to increase the communication of best practices among programs and orient new employees.

All quality improvement activities will be performed with a team spirit aimed at developing the MFC Program to its fullest potential and providing the best medical foster care services possible to the children and young adults that it serves.

ATTACHMENT I Medical Foster Parent Pre-Service Training Procedures and Responsibilities

The following information and instructions relate to how to schedule a Medical Foster Parent Pre-Service Training and how the responsibilities are designated:

To Schedule a Training:

1. At least six students should be lined up for a parent training but no more than 20. See under "Area MFC Staff Responsibilities" for pre-training parent screening requirements.
2. At least one month in advance of the need for a parent training, the area MFC Program Coordinator shall contact the Children's Medical Services (CMS) Central Office MFC Social Service Consultant to identify the need for trainers and schedule a training.
3. The MFC Social Service Consultant will select authorized Regional Trainers for the upcoming training comprised of a MFC RN and a MFC Social Service Worker (SW). Regional Trainers will be selected based on their proximity to the area and their availability.
4. When trainers are identified, the MFC Social Service Consultant will contact the area MFC Program Coordinator to schedule the training.

Central Office Staff Responsibilities:

1. Responsible for selecting and arranging Regional Trainers for each area MFC parent training. The Regional Trainer will be contacted to determine if their workload allows for training. If the trainer agrees, Central Office will request permission from the Regional Trainer's supervisor and/or Nursing Director prior to arranging training.
2. Prepare and disseminate an "Upcoming MFC Parent Training" memo to the area office requesting the training.
3. Prepare and disseminate training certificates to the area office requesting the training.
4. Coordinate with Regional Trainers as needed.
5. Participate with Regional Trainers as needed.
6. Maintain an e-mail distribution list on the computer network for ease of communication between Regional Trainers.
7. Receive, review and maintain the training evaluation forms that the students complete at the end of each training.

MFC Regional Trainers' Responsibilities:

1. When a team of Regional Trainers is selected, the Regional Trainer SW will be the contact person who will coordinate with the area office MFC Coordinator regarding the upcoming training.
2. The Regional Trainers will conduct the training as instructed in the certified MFC Train the Trainer class, using the current MFC Program Medical Foster Parenting Instructor's Guide and presentation materials. The area MFC staff will be expected to assist with class arrangements, class management, etc.

3. The Regional Trainer SW will collect the training evaluation forms and send these to the MFC Social Service Consultant at CMS Central Office.
4. The Regional Trainer RN will maintain all training supplies in a traveling bin.
5. Regional Trainers will submit travel expenses to CMS Central Office for reimbursement at:

HCMS
4052 Bald Cypress Way, Bin A-06
Tallahassee, FL 32399-1700
Attn: Quality Practice & Management Unit

Area MFC Staff Responsibilities:

1. In order to pre-qualify for the training, all students must have completed a DCF-approved parent preparation training course provided by the CBC. After receiving the completed and legible MFC Parent Profile and a copy of their High School Diploma from the prospective MFC parent; the MFC Coordinator must review the foster parent's Parent Profile from their DCF-approved parent preparation training course and their most recent CBC licensing study, if applicable. Area MFC staff must complete a pre-training home visit with the prospective MFC family, a written summary of the interview and home inspection findings, and recommend the parent for this training. When six to 20 pre-screened students are recommended, the area MFC Coordinator may schedule a training.
2. Contact the MFC Social Service Consultant at CMS Central Office regarding the need for MFC parent training with the necessary information regarding estimated number of students, training location, and tentative training dates.
3. The area MFC Program Coordinator will serve as the contact to communicate and coordinate the upcoming training with the Regional Trainers.
4. Assist the Regional Trainers with their travel arrangements. They will be new to your area and unfamiliar with traffic and travel timeframes, etc.
5. The area MFC Program Coordinator will maintain a master copy of all printed materials (pre-reading and in-class documents).
6. At least a month prior to the training, the area MFC Program Coordinator will copy and send a set of printed pre-reading materials to each student scheduled for the upcoming training.
7. Prior to the training, the Program Coordinator will copy the in-class training materials and place them in a 3-ring binder for each student scheduled for the upcoming training.
8. Arrange for the training room, contact students with time, location, date, etc.
9. Arrange for the training amenities to include cardboard name tents for each student and daily sign-in sheets and pens for the students, as well as a computer with a compact disc drive, LCD projector, projector screen, and a white board or chalkboard, or easel and flip chart with appropriate markers for the trainers.
10. An Area MFC staff person must participate (be in attendance) during the training at all times. This person must arrive at least 30 minutes in advance of the training to assist with the room set up, the arranging of materials, and any other assistance needed by the Regional Trainers.

11. Responsible for room cleanup at end of each day (whatever is required of the facility).

12. Following each training, maintain a training folder for each training class—folder must include:

a. A sign-in sheet of each day's attendees.
b. Copy of each student's Independent In-Class Assignments.
c. Copy of each student's training certificate.

This area office training folder must be kept as a permanent file that can be referred to when questions regarding training participants are asked.

13. Three months after completion of the training, prepare a simple e-mail report to the MFC Social Service Consultant at CMS Central Office regarding the status of the class participants - how many became Medicaid providers, how many have begun serving children, etc. (Due to the high cost of providing the training and knowing there are many "drop outs", we are interested in knowing the drop-out rate, etc.)

This page intentionally left blank

ATTACHMENT II Medical Foster Care Medical Director Recommendation For MFC Transfers, Discharges, and All Children Entering MFC Home
Administrative Record

Child:_____ DOB:_____

Diagnoses:_____ Sex:_____ Level of Reimb:_____

Please check appropriate selection:

____ Admitted to Medical Foster Care

____ Temporary Transfer to Another Medical Foster Care Home

Reason:_____

Anticipated Return Date:_____

____ Transfer to Another Medical Foster Care Home

Reason:_____

____ Discharged from Medical Foster Care

Reason:_____

____ Other: Non-Medical Child Placed into MFC Home

Date of Activity:_____ Was Child Moved? Yes____ No____

If child moved, are there other children in new home? Yes____ No____

IF YES, COMPLETE PAGE TWO OF THIS FORM. (N/A FOR MFC DISCHARGES)

Moved From:_____ Moved To:_____

_____ _____

_____ _____

MEDICAL DIRECTOR STATEMENT: **I have reviewed all information available regarding this child and recommend the activity checked above. I have listed my concerns, if any, on page two of this form.**

_____ _____
MFC Medical Director Signature Date

_____ _____
MD Verbal Recommendation MD / MFC Staff Sign. Date / Time
cc:

ATTACHMENT II
Page 2

Medical Foster Care Medical Director Recommendation
For MFC Transfers, Discharges, and All Children Entering MFC Home
Administrative Record

Complete page 2 for listing other children in MFC home and / or MD concerns.

Child:_____ DOB:_____

Child Moved to MFC Home of:_____

Please check appropriate selection:

____ MFC Child Moved into Home with Other Children

____ Non-Medical Child Moved into Home with MFC Children

List the children currently residing in this home:

Child's Name	DOB	Diagnoses	Level of Reimbursement or Non-Medical Relationship to MFC Parents

____ MFC Medical Director's Concerns (if any):

_____ _____
MFC Medical Director Signature Date

_____ _____
MD Verbal Recommendation / MFC Staff Sign. Date / Time

cc:

ATTACHMENT III Temporary Plan of Care

1) Name:		**Date of Birth:**	**Medicaid ID:**
2) Names, Phone Numbers (Doctors, Family, Case Managers, Other):			
3) Level of Reimbursement:	**4) Start of Care Date:**	**5) First DOS:**	**Last DOS:**
6) Primary ICD-9 Code:	**Primary Diagnosis Description:**		
7) Additional ICD-9 Code(s):	**Additional Diagnosis Description(s):**		
8) Diet (Include Child-Specific Feeding Instructions): **9) Treatments and Interventions by the Medical Foster Care Parent (Duration, Frequency, Stop Date):** **10) Treatments and Interventions by Other Providers (Provider, Frequency, Stop Date):**			
11) Coordination of Treatment and Interventions (Scheduling, Transportation, Etc.):			
12) Durable Medical Equipment and Medical Supplies:			
13) Child-Specific Safety Measures:			
14) Child-Specific Functional Limitations (Include those related to daily living activities):			
15) Activities Permitted or Restricted:			
16) Methods of Teaching the Child, Family Members, or Other Caregivers:			
17) Short-Term Medical or Rehabilitation Goal(s):			
18) Long-Term Medical or Rehabilitation Goal(s):			
19) Foster Care Case Plan Goals:			

ATTACHMENT III
Page 2

Name:	**DOB:**
20) Allergies and Description of Reaction:	

21) Medications	**Dose**	**Frequency**	**Route**	**Start Date**	**Int**	**Stop Date**	**Int**
1:							
2:							
3:							
4:							
5:							
6:							
7:							
8:							
9:							
10:							
11:							
12:							
13:							
14:							
15:							
16:							
17:							
18:							
19:							
20:							
21:							
22:							
23:							
24:							
25:							

Signature and Credentials	**Initials**	**Signature and Credentials**	**Initials**

Total Pages: _____	**Signature and Credentials**	**Date**
Medical Foster Care Nurse		
Medical Foster Care Physician*		

*Physician's signature indicates recommend of the Medical Foster Care Plan of Care.

ATTACHMENT IV Medical Foster Care Child-Specific Training Verification

Child's Name: _____ DOB: _____

Dx: _____ MFC Parent Name: _____

Trainee Name: _____ Relationship: _____

Teaching Method Code:

E – Verbal Explanation
D – Demonstration
AV – Audio Visual
P – Printed Material
V – Vendor
S – Supplies/Equipment

Evaluation Code:

S – Successful Demonstration
UV – Understanding Verbalized
A – Need Additional Instruction

Instructor Name: _____ Initials:_____

Instructor Name: _____ Initials:_____

Mandatory Instructions Reviewed **Date:**_____

_____Handwashing _____CPR/First Aid _____Confidentiality _____Fire Drill
_____Universal Precautions _____Hurricane Disaster Plan _____Hazardous Waste

Comments	Date, MFC RN Initials	Date, Instructor Initials	Teach Code	Eval Code	Comments	Date, MFC RN Initials	Date, Instructor Initials	Teach Code	Eval Code
Reviewed the following Diagnoses of the Child:					Medication Administration & Side Effects:				
Temperature < 1 Year > 1 Year					Measurements: Head Circum, Height, Weight, Other				
Pulse: - Apical - Peripheral					Blood Pressure				
Cast Care					Wound/Skin Care				
Perineal Care					Catheterization: Clean/Sterile				
Gastronomy Tube: - Feeding - Care - Insertion - Skin Care					Nasogastric Tube: - Feeding - Care - Insertion - Skin Care				

ATTACHMENT IV
Page 2

Medical Foster Care Child-Specific Training Verification

Child's Name: _____ DOB: _____

Comments	Date, MFC RN Initials	Date, Instructor Initials	Teach Code	Eval Code	Comments	Date, MFC RN Initials	Date, Instructor Initials	Teach Code	Eval Code
IICP/Neuro Signs					Cardiology /Pulmonary Assessment				
Pulse Monitor					Apnea Monitor				
Enteral Pump					Reflux Precautions				
Oxygen Administration					Suctioning (Indicate Type):				
Tracheostomy Care/Change					Ostomy Care: - Colostomy - Urostomy - Vesicostomy				
Seizure Precautions/Care					Specimen Collection				
Positioning & Adaptive Equipment					Equipment Care (Indicate Type):				
Vascular Line (Indicate Type):					Other				
Other					Other				

Comments:

_____
_____
_____
_____
_____
_____
_____
_____

The Provider listed above ___ has ___ has not satisfactorily completed and/or adequately demonstrated skills and ability necessary to provide the care for the child listed above.

MFC RN Signature: _____ Date: _____
Trainee Signature: _____ Date: _____

ATTACHMENT V Medical Foster Parent Certificate of Approval

MEDICAL FOSTER PARENT

CERTIFICATE OF APPROVAL

(name here)

who lives at

(address here)

has met Children's Medical Services' requirements to participate in the Medical Foster Care Program

Effective Dates: From To
based on continuous compliance with Medical Foster Care standards

_____

(MD's typed name here)
Medical Foster Care Medical Director
(your agency's name here)

This certificate is not a foster care license and does not guarantee placement of medical foster children by the Department of Children & Families or their contracted agents

This page intentionally left blank

ATTACHMENT VI Rights and Responsibilities of MFC Parents

Responsibilities Include:

- Submit current copies of the foster care license, Medical Foster Care (MFC) Pre-Service Training Certificate, and the signed Medical Foster Parent Certificate of Approval with the Medicaid provider enrollment application to Medicaid Enrollment Services;

- Participate in Medicaid's MFC provider training on Medicaid claims submission and billing;

- MFC parents must obtain the recommendation and approval of the MFC medical director by contacting the MFC team prior to all child placements into their home, including regular foster children. They are not to accept a child placement directly from the child placing agency without obtaining this MFC MD recommendation;

- Parents are highly encouraged to accept older children and youth in MFC due to the increased rate of this age group with special health care needs;

- Receive child-specific training for every MFC child in care and demonstrate competency to the MFC registered nurse (RN) or other professional designated by program staff for all procedures required to care for each child placed in the MFC home;

- Provide a family-centered living environment to children in the MFC home. Medical foster children will be included in all routines of family life, which are not precluded by medical or developmental conditions;

- Provide full-time care to MFC children. The parent, as a Medicaid provider of MFC services, must be available to provide full-time care or designate care to a baby-sitter that has been approved by the MFC RN;

- Obtain a baby-sitter and inform MFC staff of every baby-sitter which the parent intends to use and arrange for approval by the MFC RN. All baby-sitters must receive approval by the MFC RN. No MFC parent will leave a MFC child with a person who has not been approved by the MFC Program;

- Follow the plan of care as approved by the MFC Medical Director;

- Inform the MFC RN or other designated staff of all changes in the plan of care within 24 hours of the change occurring; of all changes in the child's condition that would change the current plan of care or the child's level of reimbursement; of all visitations with birth family members; and of any situations, incidents or occurrences which may adversely affect the overall condition of the child;

- Inform the primary care physician of all changes in the child's condition which would change the current plan of care;

ATTACHMENT XVI
Page 2

- Keep all medically related appointments. Notify MFC RN of the outcome of all appointments. If an appointment must be cancelled, the rescheduling of the appointment must be made in a timely manner so that the child can receive necessary medical services;

- Document in the in-home record in accordance with the MFC Statewide Operational Plan. Daily progress notes by the MFC parent will include narrative documentation that notes the care the parent has provided in accordance with the treatment outlined in the plan of care, indicating the child's condition, psychosocial issues, and any other significant events in the child's day-to-day care. Detailed
information must be included on outcomes from appointments, telephone or face to face contacts, and school meetings concerning the child;

- Transport children to all medical appointments, therapies, to school, if necessary, and to visits with birth family;

- Inform the MFC Program staff of all changes which affect the circumstances of the foster family such as changes in the MFC parent's health, employment, or MFC family emergencies, which would affect the MFC parent's ability to care for the child;

- Notify the MFC staff each time the MFC parent will be away from home for more than one day and obtain recommendations for alternative caregiver arrangements for MFC children in their care;

- Provide advance notification to the MFC Program staff each time the MFC parent plans to travel with their MFC children. Travel destination and name of a hospital with an emergency room at the travel destination must be provided to the MFC RN.

- Adhere to all Department of Health (DOH), Department of Children and Families (DCF) and Medicaid policies and guidelines regarding patient and family confidentiality, attend DOH Security Training, sign a security statement of understanding form, and attend HIPAA training;

- Attend Children's Multidisciplinary Assessment Team (CMAT) staffings upon notification by the team;

- Attend MFC placement staffings or other staffings upon notification from the MFC staff;

- Attend permanency staffings and judicial reviews;

- Receive 12 annual in-service training hours and current Infant, Adult and Child CPR and First Aid certification as required by the MFC Program. CPR and First Aid courses must be taught by a live instructor;

- Maintain current foster care license and Medicaid provider status;

- Be responsible for billing Medicaid for MFC Personal Care Services according to Medicaid policy;

- Provide training to birth families or foster or adoptive families on the care of the children placed in the MFC home when such training is included in the child welfare case plan. If the MFC parent is comfortable with the family members they are training, they are encouraged to provide this training in the MFC home. This provides for a relaxed atmosphere for training personal care such as bathing and hair care and role models medical procedures in a home setting. Training provided to families will be coordinated with the MFC staff. Training of the family in which the child will be placed needs to be completed prior to the child's discharge from MFC when permanency goals are achieved;

- Parents are highly encouraged to keep MFC children in their homes, even when they are better physically and they are discharged from MFC until a permanent placement is arranged for them such as reunification with their family or adoption. This reduces the psychological trauma and long-term effects that disruption from a home placement can cause for a child;

- Provide support to the new caretaker during and after the actual transition of the child, and

- When withdrawing from the MFC Program, MFC parent providers are to send a signed letter with their name, Medicaid provider number, and the date they are withdrawing from the MFC Program to the current Medicaid fiscal agent.

Rights Include:

- Have the right to apply to be a Medicaid provider of Medical Foster Care Personal Care Services and receive reimbursement for services as stipulated in the provider agreement;

- Have the right to be reimbursed for transportation provided by the MFC parent for medical appointments, special care, educational and vocational training, or visits to parents and relatives by the CBC at the current CBC rate for mileage;

- Have the right to receive foster care board payments or shelter care board payments according to the current DCF reimbursement rates for each child placed;

- Have the right to accept medical foster children, referred by the Medical Foster Care Program, for care based on the parent's skills and ability to provide care;

- Have the right to access the DOH, Children's Medical Services Complaint and Grievance Policy and Procedures to address concerns related to CMS services for MFC children, and

- Maintain all other rights established by the Legislature for family foster homes through Chapter 409.175, Florida Statutes.

This page intentionally left blank

ATTACHMENT VII PROSPECTIVE MEDICAL FOSTER PARENT PROFILE
Administrative Record

Instructions:

Coordinator: Please have each parent who wishes to become a Medicaid Provider of Medical Foster Care, complete the form.

Foster Parent: Please complete the information below and return to the Medical Foster Care Program.

PART I GENERAL

Foster Parent Name: _____

Date of Birth: _____ Race: _____ Marital Status: _____

Street Address: _____

Mailing Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

List names of all family members and others, including foster children, living in your home:

1. _____ DOB: _____ Relationship: _____
2. _____ DOB: _____ Relationship: _____
3. _____ DOB: _____ Relationship: _____
4. _____ DOB: _____ Relationship: _____
5. _____ DOB: _____ Relationship: _____
6. _____ DOB: _____ Relationship: _____
7. _____ DOB: _____ Relationship: _____
8. _____ DOB: _____ Relationship: _____
9. _____ DOB: _____ Relationship: _____

ATTACHMENT VII
Page 2

Foster Parent Name: _____

PART II EDUCATION AND EXPERIENCE

Education (begin with most recent school)

School	Diploma / Degree	Date
1.		
2.		
3.		
4.		

Licensure (List any current professional license(s) that you have)

_____

Health Related Courses and / or Training

School	Course Title	Date
1.		
2.		
3.		

References (Please include 3 references of health professionals or personal references we may contact)

Name	Relationship	Address	Phone Number
1.			
2.			
3.			

ATTACHMENT VII
Page 3

Foster Parent Name: _____

Employment Experience

1. Employment or Volunteer Setting: _____

Your Position or Role: _____

Period of Employment: From _____ To _____ HRS / WK _____
(MO/YR) (MO/YR)

Your Responsibilities / Type of Care You Provided: _____

_____

_____

_____

Reason for Leaving: _____

2. Employment or Volunteer Setting: _____

Your Position or Role: _____

Period of Employment: From _____ To _____ HRS / WK _____
(MO/YR) (MO/YR)

Your Responsibilities / Type of Care You Provided: _____

_____

_____

_____

Reason for Leaving: _____

3. Employment or Volunteer Setting: _____

Your Position or Role: _____

Period of Employment: From _____ To _____ HRS / WK _____
(MO/YR) (MO/YR)

Your Responsibilities / Type of Care You Provided: _____

_____

_____

ATTACHMENT VII
Page 4

Foster Parent Name: _____

Reason for Leaving: _____

Parenting Experience

1. Are you currently a licensed foster parent? Yes _____ No _____

If not, at what stage are you in the process of becoming licensed? _____

_____

2. How did you learn about Medical Foster Care? _____

_____

3. Describe your experience in caring for children: _____

_____

_____

_____

4. Describe your experience in caring for foster children: _____

_____

_____

_____

5. Describe your experience in caring for medically complex children: _____

_____

_____

_____

PART III FAMILY LIFE AND FINANCES

A. What effect do you think being a medical foster parent will have on the amount of time you and your spouse and family spend together?

_____

_____

ATTACHMENT VII
Page 5

Foster Parent Name: _____

B. The Florida Administrative Code requires that foster parents have sufficient income to assume the security and stability of their family. Please describe your family's financial situation based on this knowledge.

1. Will you be financially able to provide for a child for four to six weeks prior to receiving the first board or Medicaid check? _____Yes _____No

2. Is your family experiencing heavy debt or financial distress? _____Yes _____No

3. What financial problems would you foresee with the addition of another person in your home?

_____

_____

4. Monthly combined gross income: _____

5. Monthly total debts: _____

PART IV TRANSPORTATION

Driver's License #: _____

Spouse's Driver's License #: _____

Do you have a reliable car? _____Yes _____No

Many of our physician specialists and treatment centers are not located in your area. Are there any problems driving out of town for physician appointments? (Please list)

_____

Sometimes our children have to be hospitalized and a caretaker needs to be with them. Do you have any problems staying with a child in the hospital, including out of town hospitals? (Please list)

_____

PART V SIGNATURES

_____ _____
Prospective Medical Foster Parent Date

_____ _____
Spouse Date

This page intentionally left blank

ATTACHMENT VIII Tuberculosis Skin Testing Risk Screen
Administrative Record

For all adults living in a Medical Foster Care home: Florida guidelines for tuberculosis (TB) skin testing have changed. Skin testing is now recommended only for groups at high risk to progress from infection to disease. Routine TB skin testing is no longer recommended. Please complete this form to help us determine if you fall into a high-risk group that requires further medical evaluation under the new guidelines.

Risk of Exposure Questionnaire

Please check YES or NO in response to the following questions since your most recent PPD or CXR:

1. Are you a recent contact to an infectious case of tuberculosis? Yes □ No □
2. Have you ever had an organ transplant? Yes □ No □
3. Are you a recent (within the last 5 years) immigrant from a country with a high rate of TB? If yes, what country?_____ Yes □ No □
4. Have you ever injected drugs? Yes □ No □
5. Have you been in jail, prison, or a nursing home? Yes □ No □
6. Have you ever worked in a lab that processed TB specimens? Yes □ No □
7. Do you have any of the following medical conditions?
    a. Diabetes Yes □ No □
    b. Chronic kidney failure with dialysis Yes □ No □
    c. Leukemia Yes □ No □
    d. Lymphoma Yes □ No □
    e. Cancer of the head, neck, or lung Yes □ No □
    f. Stomach surgery Yes □ No □
    g. Immune problems (diagnosed with HIV disease or taken Prednisone longer than one month) Yes □ No □
8. Have you ever been told you have an abnormal chest x-ray? Yes □ No □
9. Have you had any of the following symptoms recently?
    a. Cough an/or hoarseness lasting more than 3 weeks Yes □ No □
    b. Recently unexplained weight loss Yes □ No □
    c. Fever or night sweats for more than a week Yes □ No □
    d. A productive cough or coughed up blood Yes □ No □

If you answer NO to all of these questions, you do not fall into one of the groups that should receive a skin test. This determination is based on current standards provided to the Florida Department of Health and from the Centers for Disease Control and Prevention, an agency of the U.S. Government, and endorsed by the American Lung Association of Florida. If you answered YES to any of these questions, you will be required to seek further evaluation from your private physician or local County Health Department.

Name of Person who completed this Form: _____

Date of Birth of Person who completed this Form: _____

MFC Nurse Signature: _____ Date: _____

This page intentionally left blank

ATTACHMENT IX Acceptable Use and Confidentiality Agreement
Administrative Record

SECTION A The Department of Health (DOH) worker and the appropriate supervisor or designee must address each item and initial.

Security and Confidentiality Supportive Data

W S

__ __ I have been advised of the location of and have access to the Florida Statutes and Administrative Rules.
__ __ I have been advised of the location of and have access to the core Department of Health Policies, Protocols and Procedures and local operating procedures.

Position Related Security and Confidentiality Responsibilities

I understand that the Department of Health is a unit of government and generally all its programs and related activities are referenced in Florida Statutes and Administrative Code Rules. I further understand that the listing of specific statutes and rules in this paragraph may not be comprehensive and at times those laws may be subject to amendment or repeal. Notwithstanding these facts, I understand that I am responsible for complying with the provisions of this policy. I further understand that I have the opportunity and responsibility to inquire of my supervisor if there are statues and rules which I do not understand.

__ __ I have been given copies or been advised of the location of the following specific Florida Statutes and Administrative Rules that pertain to my position responsibilities:

_____
_____
_____

__ __ I have been given copies or been advised of the location of the following specific core Department of Health Policies, Protocols and Procedures that pertain to my position responsibilities:

_____
_____
_____

__ __ I have been given copies or been advised of the location of the following specific supplemental operating procedures that pertain to my position responsibilities:

_____
_____
_____

__ __ I have received instructions for maintaining the physical security and protection of confidential information, which are in place in my immediate work environment.

I have been given access to the following sets of confidential information:

__ __ _____
__ __ _____
__ __ _____

Penalties for Non Compliance

__ __ I have been advised of the location of and have access to the Department of Health Personnel Handbook and understand the disciplinary actions associated with a breach of confidentiality.
__ __ I understand that a security violation may result in criminal prosecution and disciplinary action ranging from reprimand to dismissal.
__ __ I understand my professional responsibility and the procedures to report suspected or known security breaches.

The purpose of this acceptable use and confidentiality agreement is to emphasize that access to all confidential information regarding a member of the workforce or held in client health records is limited and governed by federal and state laws. Information, which is confidential, includes the client's name, social security number, address, medical, social and financial data and services received. Data collection by interview, observation or review of documents must be in a setting that protects client's privacy. Information discussed by health team members must be held in strict confidence, must be limited to information related to the provision of care to the client, and must not be discussed outside the department.

_____	_____	_____
DOH Worker's Signature	Date	Supervisor or Designee Signature

DH 1120, revised July 20,2007

ATTACHMENT IX
Page 2

SECTION B Information Resource Management (Initial each item, which applies)

The member of the workforce has access to computer related media
__ Yes. Has each member of the workforce read and signed section B
__ No. It is not necessary to complete section B

Understanding of Computer Related Crimes act, if applicable.

The Department of Health has authorized you to have access to sensitive data through the use of computer-related media (e.g., printed reports, microfiche, system inquiry, on-line update, or any magnetic media).

Computer crimes are a violation of the department's disciplinary standards and in addition to departmental discipline; the commission of computer crimes may result in felony criminal charges. The Florida Computer Crimes Act, Ch. 815, F.S., addresses the unauthorized modification, destruction, disclosure or taking of information resources.

I have read the above statements and by my signature acknowledge that I have read, and been given a copy of, or been advised of the location of the Computer Related Crimes Act Ch. 815, F.S. I understand that a security violation may result in criminal prosecution according to the provisions of Ch. 815, F.S., and may also result in disciplinary action against me according to Department of Health Policy.

The minimum information resource management requirements are:

- Personal passwords are not to be disclosed. There may be supplemental operating procedures that permit shared access to electronic mail for the purpose of ensuring day-to-day operations of the department.
- Information, both paper-based and electronic-based, is not to be obtained for my own or another person's personal use.
- Department of Health data, information, and technology resources shall be used for official state business, except as allowed by the department's policy, protocols, and procedures.
- Only approved software shall be installed on Department of Health computers (IRM Policy NO.50-7).
- Access to and use of the Internet and email from a Department of Health computer shall be limited to official state business, except as allowed by the department's policy, protocols, and procedures.
- Copyright law prohibits the unauthorized use or duplication of software.

_____	_____	_____
DOH Worker's Signature	Date	Supervisor or Designee Signature
_____	_____	_____
Print Name	Date	Print Name

W=Worker S=Supervisor

DH 1120, revised July 20, 2007

Medical Foster Care Parent Supplemental Information Security

Maintaining Medical Foster Care Children's In-Home Records :

- In-home records must be kept in an area which doesn't allow access by visitors or other unauthorized individuals.
- Information containing Medical Foster Care children's names and other confidential content will be protected from unauthorized individuals. This information will be maintained in areas with limited access. It should never be left unsecured.
- The exterior cover of the in-home record should never be flagged to identify sensitive information, other than known allergies to specific medications. For example, records of Medical Foster Care children who are HIV positive should not be flagged.

Faxing Confidential Information:

- Fax machines must be kept in areas which are not accessible to unauthorized individuals.
- Authorization from Medical Foster Care staff to release medical information must be obtained prior to transmitting confidential medical information.
- A cover sheet containing the sender's name, address, phone number, and the following required security paragraph must accompany all transmissions: "This transmission may contain material that is CONFIDENTIAL under federal and Florida statues and is intended to be delivered to only the named addressee. Unauthorized use of this information may be a violation of criminal statues. If this information is received by anyone other than the named addressee, the recipient will immediately notify the sender at the address or the telephone number above and obtain instruction as to the disposal thereof. Under no circumstances will this material be shared, retained or copied by anyone other than the named addressee." A note must be made in the Medical Foster Care child's in-home record indicating the information sent.
- HIV/AIDS information cannot be faxed.

Verbal Communication:

- Discussions about Medical Foster Care children should be limited to those individuals with "a need to know.". Never discuss confidential information with friends, family members, or other individuals who do not have "a need to know."
- All telephone calls in which confidential information is discussed must be made from an area that ensures that confidentiality is maintained.

Mailing Confidential Information:

- Double enveloping is encouraged when mailing confidential or sensitive information.

ATTACHMENT IX
Page 4

Electronic Mail:

- E-mail communications are public record and not secure.
- The names of Medical Foster Care children and their relatives must not be included in e-mail communications.

Release of Confidential Medical Information:

- Authorization from Medical Foster Care staff to release medical information to individuals with "a need to know" must be obtained prior to copying and releasing documents containing confidential medical information.

Transporting Confidential Medical Information :

- In-home records and other confidential medical information will never be left unattended during the transport process. Never leave in-home records unattended in your vehicle or in the custody of unauthorized persons.

Source: Florida Department of Health Information Security Policy

ATTACHMENT X Annual MFC Parent In-Service Training Log
Administrative Record

Parent Name:_____ **MFC MD Approval: From _____ To _____**

Twelve training hours needed per MFC MD Approval year

- 6 hours must be medically related
- 2 hours must be DOH Security, HIPAA, and MFC Policy & Procedure
- 2 hours can be from CPR or First Aid
- 2 hours can be psychosocially related

All training must be prior approved by MFC staff

Date	Course Title	Instructor	Training Hours

This page intentionally left blank

ATTACHMENT XI Medical Foster Care Parent Skills Assessment
Administrative Record

Date: _____ Medical Foster Parent:_____

This document is used as a tool to complete an annual evaluation and re-designation of the foster parent's status as a medical parent. This tool can also be used when teaching assistance or corrective action is indicated and at any time the program staff needs to assure that minimum standards are being met. Copies of this form are provided to the medical foster parent and filed in the MFC Administrative Record. A copy may be sent to the foster care licensing agency upon request.

Standards will be assigned a rating of: "Exceeds Standard", "Meets Standard", or "Does Not Meet Standard". Comments are not required for the "Meets Standard" rating.

Section 1: Children in the Home

Name	DOB	Date Placed	Level of Care	Date/Reason for Removal

Section 2: Direct Care

☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	2(a) Applies specific health and developmental information for each child placed in the home. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	2(b) Recognizes simple cause and effect in supervision and caring for children and acts or reacts accordingly to situations that could have negative effects. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	2(c) Follows directions of health care professionals for the care of children. Verifies orders when there are significant changes; seeks direction and explanations when not sure of orders. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	2(d) Performs therapeutic tasks and procedures correctly and in a timely manner. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	2(e) Performs therapeutic tasks and procedures in a comforting, non-threatening manner so as to decrease the child's fear or anxiety and increase their understanding and acceptance of those interventions. Comments:

ATTACHMENT XI
Page 2

Date: _____ Medical Foster Parent: _____

☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	2(f) Able to make appropriate, independent decisions in crisis situations for the welfare of the child. Comments:

Section 3: Record-Keeping Standards

☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	3(a) Consistently and accurately documents child's progress, treatments and interventions according to program staff instructions. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	3(b) Consistently and accurately maintains the child's In-Home record according to program staff instructions. Comments:

Section 4: Organization Standards

☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	4(a) Consistently able to schedule and keep all appointments for the medical child including medical, therapeutic, school-related, and administrative. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	4(b) In-Home records, documents, medicines, and equipment have permanent places in the home and are readily accessible. Required information is properly posted. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	4(c) Manages and maintains personal family budget to prevent interruption in services and or supplies needed for the medical child. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	4(d) Is able to maintain the physical standards of the home including housekeeping practices, indoor, and outdoor upkeep. Comments:

Section 5: Support & Communication Standards

☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	5(a) Asks for appropriate assistance in a timely manner to provide competent care for the child. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	5(b) Regularly asks doctors and health care professionals questions about the child's condition; finds out who to talk to about concerns; works with schools and agencies needed to provide services or assist with obtaining services. Advocates for the child. Comments:

ATTACHMENT XI
Page 3

Date: _____ Medical Foster Parent: _____

☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	5(c) Readily shares complete information to appropriate persons in a timely manner. Consistently updates program staff on changes. Changes include: the child's health, foster care case, household members, or other stressors. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	5(d) Interacts with child's family according to the case plan. Teaches and coaches family members who visit with the child and shares information and informs family of medical appointments and therapies. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	5(e) Treats, interacts and provides for the child as a parent. Pays attention to the social, emotional, and intellectual needs of the child and takes action to assure those needs are met. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	5(f) Always leaves the child with a qualified sitter, approved by the program. Has a plan for the care of own children in case of emergency with medical child. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	5(g) Medical Parent is able to monitor their own stress level and work with staff to arrange for extra help, vacation, or other activities to assure their own mental and emotional health. Comments:

Section 6: Other Program Requirements

☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	6(a) Completed 12 hours of in-service training during the past licensing year including Department of Health Security and Health Insurance Portability and Accountability Act (HIPAA) training. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	6(b) Performs fire safety drills with the entire family within 7 days of each new MFC child admission. Notifies MFC staff of drills in a timely manner. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	6(c) Maintained certification in infant, adult, and child CPR & First Aid. Comments:
☐Exceeds Standard ☐Meets Standard ☐Does Not Meet Standard	6(d) Has completed Hepatitis B vaccination series, Titer, or Declination Form. Has completed required tuberculosis testing or screening. Comments:

Section 7: Additional Comments

ATTACHMENT XI
Page 4

Date: _____ Medical Foster Parent: _____

Section 8: History of Teaching Assistance and Corrective Action Plans

Section 9: Recommendations and Signatures

- ☐ The above Medical Parent exceeds the minimum program standards.
- ☐ The above Medical Parent meets the minimum program standards.
- ☐ The above Medical Parent is not in compliance with all program standards and has entered into a Corrective Action Plan. Medical Parent status is temporarily continued and standards will be reviewed in **(enter date).**
- ☐ The above Medical Parent is currently participating in a Corrective Action Plan but has continued to not meet standards and termination of Medical Parent status is recommended.
- ☐ The above Medical Parent does not meet the minimum program standards, does not desire to enter into a Corrective Action Plan, and Medical Parent status is therefore terminated.

_____ _____
MFC Nurse Signature Date

_____ _____
MFC Social Worker Signature Date

_____ _____
MFC Parent Signature (optional) Date

_____ _____
MFC Medical Director (optional) Date

ATTACHMENT XII Medical Foster Care Environmental Review

Administrative Record

Date: _____ Scheduled Visit: YES / NO

Medical Home: _____ Phone: _____

Address: _____

	YES	NO	N/A	COMMENTS
1. Current foster care license & fire evacuation routes posted				
2. Disaster plan complete, up to date, & posted				
3. Fire drill log current with all new MFC admissions & posted				
4. Was the home and vehicle smoke-free?				
5. If previously smoked in home, extensive cleaning completed				
6. Building exterior & grounds safe & free of clutter & debris				
7. All doors to pool area locked. Self closing gates functional				
8. Flotation devices are available for all children unable to swim				
9. All garbage containers covered /stored in inaccessible location				
8. Interior clean, neat, & orderly				
10. Toys & equipment are age appropriate and clean				
11. Chlorine bleach/1:10 bleach to water solution available				
12. Antibacterial soap & paper towels at sink				
13. Disposable gloves available at diaper changing area				
14. Sharps container & red bags used as appropriate				
15. Home is free of infestations of insects & rodents				
16. Telephone & utilities in operation				
17. Home has heating which is vented & air conditioning				
18. Lighting in child's room is adequate to allow for reading & medication administration				

ATTACHMENT XII
Page 2

Date: _____ Medical Home: _____

	YES	NO	N/A	COMMENTS
19. Home has adequate space for medical equipment & supplies				
20. Is the home free of architectural barriers that prevent the child's participation in normal activities?				
21. All exits, stairways, ramps, corridors, & fire escapes are free from storage, clutter, or obstruction				
22. Child's room has adequate outlets				
23. Fluoride in water				
24. Sleeping arrangements for MFC children are appropriate (each has own bed/crib, don't share room w/opposite sex if over 3 years, don't share room with parents if over 1 year)				
25. All medicines including over the counter drugs are locked up				
26. Cleaning supplies are locked up				
27. Local fire and rescue service notified of home in writing				
28. Are the same adults staying in the home since the last review?				
29. All persons in home have been appropriately screened				
30. Reliable transportation is available 24 hours				
31. Each child has a reliable car seat				
32. The physical and mental health of everyone in the household has remained the same since the last review				

ATTACHMENT XII
Page 3

Date: _____ Medical Home: _____

	YES	NO	N/A	COMMENTS
33. Any pets in the home (list) **A. Pet type**_____ **Pet size**_____ **Pet's behavior**_____ **B. Pet type**_____ **Pet size**_____ **Pet's behavior**_____ **C. Pet type**_____ **Pet size**_____ **Pet's behavior**_____ **D. Pet type**_____ **Pet size**_____ **Pet's behavior**_____				
34. All children in home that turned 18 have Hepatitis B & TB documentation				
35.				
36.				
37.				

Is a follow up review required?_____ Date of planned follow up review_____

Home Evaluator's Signature_____

MFC Medical Director Signature_____

MFC Parent Signature (optional)_____

This page intentionally left blank

ATTACHMENT XIII Medical Foster Care Disaster Preparedness Plan

Date of MFC Medical Director Approval of Home:_____

Medical Foster Care Parent(s):_____

Home Address and County:_____

Home Phone:_____ Cell Phone:_____ Other:_____

I. Select the appropriate letter from the following Evacuation Destinations based on the *most complex* care requirements for each child in the home:

H = Hospital (admission), S = Special Needs Shelter, L = Local Shelter, A = Alternate Residence

MFC Children in the Home (please enter evacuation information within 7 days of child's admission):

MFC Child Name	Admission Date	Evacuation Destination	Name of Hospital or Shelter (if applicable)	Phone Number	Discharge Date

If Hospital or Shelter was selected, is pre-registration required? □ Yes □ No
If Yes, is pre-registration complete? □Yes □ No

II. Medical needs and interventions that may impact evacuation: *check all that apply*

□ Skilled Nursing Services or Durable Medical Equipment (access to a power source)
□ Time sensitive treatments: in which delay could jeopardize the wellbeing of the child (ex: TPN, dialysis)
□ Other:_____
□ Current needs DO NOT impact the circumstances in which evacuation would occur.

III. Local Evacuation Destination: if shelter is not established, provide an alternative location within a 50 mile radius.

Name & Address:_____

Phone Number:_____ Alternate Phone Number:_____

IV. Out of Area Evacuation Destination: if shelter is not established, provide an alternative location at least 50 miles from home.

Name & Address:_____

Phone Number:_____ Alternate Phone Number:_____

V. Personal Contact: friend or relative that can be contacted to identify your whereabouts (if not identified above):

Name & Phone Number:_____

Please note: When evacuation is advised, compliance is **mandated**. In the event you are not instructed to evacuate or are unable to vacate your residence, supplies must be available in the home and in working order at all times. Initial each item to confirm access to at least a one week's supply of the following items:

____ Medical Supplies	____ Battery-Operated Radio	____ First Aid Kit
____ Medications	____ Batteries	____ Non Perishable Food
____ Candles & Flashlight	____ Water	____ Blankets & Clothing

Additional Items:_____

This page intentionally left blank

ATTACHMENT XIV Medical Foster Care Fire Drill Log
Administrative Record

Medical Home_____

Instructions: Fire drills must be completed with the entire family within seven (7) days of each new MFC child admission and documented on this log.

Date of Fire Drill	Initials of all Children Involved in Drill	Initials of all Adults Involved in Drill	Pertinent Comments/ Modifications Needed
Example: 7/22/12	**JH, BM, RW**	**BA, SA**	**JH tripped on front step but did not get hurt. Told him to slow down.**

This page intentionally left blank

ATTACHMENT XV CMS Complaint and Grievance Policy and Procedures

POLICY:

Enrollees in Children's Medical Services (CMS) include Medicaid, KidCare, and Safety Net children served through the CMS area offices. Upon enrollment in CMS, families and providers must be advised of the process for filing complaints and grievances, which are written procedures detailing an organized process by which clients and providers may seek resolution. Services to children will not be adversely affected by any complaint or grievance action initiated on their behalf.

PROCEDURE:

I. CMS Complaint and Grievance Procedure Exceptions

A. For Medicaid recipient issues involving eligibility or termination, suspension, reduction or denial of Medicaid covered services, families must access the Department of Children and Families (DCF) Office of Appeal Hearings.

B. For Medicaid provider issues involving eligibility or reimbursement, the provider must access the Florida Division of Administrative Hearings or the court system.

C. For KidCare recipient issues involving KidCare third-party administrator enrollment and financial eligibility, families must access the Florida Healthy Kids grievance process.

D. For CMS client issues that are unrelated to CMS, families must access the respective CMS program's grievance procedures.

II. Complaint Resolution

A. A complaint is any verbal or written expression of dissatisfaction by a client regarding the administration or provision of services. Complaint resolution is the initial process used to address concerns. A complainant is the client, parent, legal guardian or provider.

B. The CMS area office Medical Director, Nursing Director, Program Administrator or Member Services representative may be notified verbally or in writing of a complaint.

C. The receipt of the complaint and a brief description of its final resolution must be documented by the staff on the CMS Complaint and Grievance Log and must be filed in the Complaint/Grievance Notebook maintained by the CMS Area Office.

D. Complaints should be attempted to be resolved through immediate interaction with the complainant or, as necessary, through scheduled conferences. Conferences should be conducted as soon as possible, not to exceed 10 business days from receipt of the complainant's notification, and should include participation by persons who have the knowledge and authority to affect resolution, as selected by the CMS area office Nursing Director or Program Administrator.

E. If the complaint is resolved to the satisfaction of the complainant, no further action is needed.

F. If the complaint is not resolved to the satisfaction of the complainant, a formal written grievance can be filed.

III. Grievance Resolution

A. A grievance is a formal, written complaint filed after the CMS Complaint and Grievance procedure or Integrated Care System's grievance procedure, as applicable, has been exhausted. A grievant is the client, parent, legal guardian or provider.

B. The grievance must be in writing, signed and dated by the grievant, and must be date stamped when received by the CMS area office. A CMS Grievance Form may be used for this purpose. If a CMS Grievance Form is not used, the essential elements on the form must be addressed in the grievance letter prepared by the grievant. Upon request, a CMS Grievance Form will be provided. The CMS area office will provide assistance in preparing the written grievance upon request.

C. The grievance must be filed within one calendar year from the date of incident that initiated the grievance. Within 10 business days after receipt of the grievance form or letter, the CMS area office must contact the grievant in writing with the scheduled date and time of the grievance meeting, which must be held within 20 business days of the receipt of the grievance form or letter.

D. The CMS area office must maintain a Complaint/Grievance Notebook in which to file all grievances, including:

1. A record of each formal grievance filed, recorded either on the CMS Grievance Form or in a document containing the elements of the form,
2. An entry in the CMS Complaint and Grievance Log for each grievance including a brief description of its final resolution, and
3. A complete description of the factual findings and the final resolution of the grievance.

E. The grievance will be reviewed by the area CMS Grievance Committee. The committee includes the CMS area office Medical Director, Nursing Director, Program Administrator, and two other CMS area office staff members who have the expertise needed to resolve the issue, as appointed by the CMS area office Nursing Director or Program Administrator.

F. The grievant may elect to attend the scheduled meeting in person or by conference call. However, if the grievant is unable to attend the scheduled meeting, the area CMS Grievance Committee will meet in his/her absence.

G. The grievance will be resolved within 40 business days after the receipt of the grievance form or letter or within 60 business days if the grievance involves the collection of information from outside the service area.

H. The resolution determined by the area CMS Grievance Committee will be communicated in writing under the signature of the area CMS area office Medical Director within 10 business days following the meeting.

I. If the grievant is dissatisfied with the final resolution by the area CMS Grievance Committee, the grievant may request that the CMS Statewide Grievance Panel review the grievance resolution.

IV. Grievance Resolution Review

A. The CMS Statewide Grievance Panel, located at CMS Central Office, is responsible for reviewing the appropriateness of the resolution determined by the area CMS Grievance Committee. The CMS Statewide Grievance Panel includes the Division Director of the relevant program and four other CMS Central Office staff members who have the expertise needed to resolve the issue, as designated by the Division Director of the relevant program.

B. The grievant must make a request in writing to the CMS area office that the CMS Statewide Grievance Panel review the grievance resolution of the area CMS Grievance Committee. Assistance by the CMS area office will be provided upon request. The CMS area office must forward the request and all documentation pertaining to the grievance to the CMS Statewide Grievance Panel.

C. All records reviewed by the CMS Statewide Grievance Panel will be maintained in the CMS Central Office.

D. Within 10 business days after receipt of the grievance review request, the CMS Central Office must notify the grievant in writing of the scheduled meeting date and time for the CMS Statewide Grievance Panel's review of the grievance. This meeting will be held within 30 business days of the receipt of the grievance review request and will be recorded.

E. The recommendations of the CMS Statewide Grievance Panel will be communicated in writing to the Deputy Secretary for Children's Medical Services within 10 business days following the meeting. A letter of final resolution will be sent to the grievant within 10 business days following the Deputy Secretary's decision. A copy will also be sent to the CMS Area Office.

F. The decision of the CMS Deputy Secretary is final for all medical issues.

G. KidCare recipients, who are not satisfied with the CMS Statewide Grievance Panel's resolution of non-medical issues, can request a review by the Florida KidCare Grievance Committee.

This page intentionally left blank

ATTACHMENT XVI Medical Foster Care Emergency Contact Information In-Home Record

Medical Foster Child: _____ DOB: _____

Medical Foster Care Nurse: _____ Telephone: _____

Medical Foster Care Social Worker: _____ Telephone: _____

Medical Foster Care Supervisor: _____ Telephone: _____

Medical Foster Care On-Call Pager or Phone: _____ Telephone: _____

Telephone: _____

Telephone: _____

Telephone: _____

Telephone: _____

Primary Care Provider: _____ Telephone: _____

Specialists:

Hospital: _____ Telephone: _____

Children and Families or Community Based Care Counselor: _____

Telephone: _____

Children and Families or Community Based Care Supervisor: _____

Telephone: _____

Emergency Services: _____ Telephone: **911**

Poison Control: _____ Telephone: _____

This page intentionally left blank

ATTACHMENT XVII Medical Foster Care Family / Agency Contact Log
In-Home Record

Medical Foster Child: _____ DOB: _____

Date	Time	Type of Contact		Who	Comments
		Phone	Person		

Type of Contact Key:

TCT = Telephone Call To **FF** = Face to Face **TCF** = Telephone Call From

M = Mail **Fax** = Facsimile **E** = E-Mail

This page intentionally left blank

ATTACHMENT XIX Medical Foster Care Progress Notes
In-Home Record

Medical Foster Child: _____ DOB: _____

DATE	PROGRESS NOTE	SIGNATURE

This page intentionally left blank

ATTACHMENT XIX Medication Flow Sheet (Medical Foster Care)
In-Home Record

Child's Name: ____________ DOB: ______ Allergies: ____________ page ____ of ____

Month/Year ____ /20____ MFC Home: ____________

Key: S = Medication given by… S = School Staff N = Private Duty Nurse H = Hospital Staff P = Parent other than the MFC Parent

Medication	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Exp. Date: Name:																																
Dose:																																
Route:																																
Times per Day:																																
Exp. Date: Name:																																
Dose:																																
Route:																																
Times per Day:																																
Exp. Date: Name:																																
Dose:																																
Route:																																
Times per Day:																																
Exp. Date: Name:																																
Dose:																																
Route:																																
Times per Day:																																

Initials: ____ Signature: ______________ Initials: ____ Signature: ______________ Initials: ____ Signature: ______________

Comments: ______________________________

This page intentionally left blank

ATTACHMENT XX (1) PRN Medication Flow Sheet (Medical Foster Care)
In-Home Record

Child's Name: ____________________ DOB: ______ Allergies: ____________________ page ____ of ____

Month/Year ____ /20____ MFC Home: ____________________

Key: S = Medication given by… S = School Staff N = Private Duty Nurse H = Hospital Staff P = Parent other than the MFC Parent

Medication	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Exp. Date: Name:																																
Dose:																																
Route:																																
Times per Day:																																
Exp. Date: Name:																																
Dose:																																
Route:																																
Times per Day:																																
Exp. Date: Name:																																
Dose:																																
Route:																																
Times per Day:																																
Exp. Date: Name:																																
Dose:																																
Route:																																
Times per Day:																																

Initials: ____ Signature: ____________________ Initials: ____ Signature: ____________________ Initials: ____ Signature: ____________________

Comments & Outcome: ____

This page intentionally left blank

ATTACHMENT XX (2) PRN Medication Flow Sheet (Medical Foster Care) - In-Home Record

Child's Name: ____________________ DOB: ________ Allergies: ____________________ page______ of ________

MFC Home: ____________________

Key: Medication given by… S = School Staff N = Private Duty Nurse H = Hospital Staff P = Parent other than the MFC Parent

PRN Medication Name:			**Dose:**		**Instruction/Times per day:**			**Route**:	
Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:
Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:
Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:
Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:

PRN Medication Name:			**Dose:**		**Instruction/Times per day:**			**Route**:	
Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:
Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:
Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:
Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:

PRN Medication Name:			**Dose:**		**Instruction/Times per day:**			**Route**:	
Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:
Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:
Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:
Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:

PRN Medication Name:			**Dose:**		**Instruction/Times per day:**			**Route**:	
Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:
Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:	Reason Given:
Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:	Outcome:
Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:	Initials:

Initials: ____ Signature:____________________ Initials:____ Signature:____________________ Initials:____ Signature:____________________

Comments: ____

This page intentionally left blank

ATTACHMENT XXI Treatment Flow Sheet (Medical Foster Care)
In-Home Record

Child's Name: ________________________ DOB: ________ Allergies: ________________________ page ______ of ________

Month/Year: ______ /20 ________ MFC Home: ________________________

Key: Treatment given by… S = School Staff N = Private Duty Nurse H = Hospital P = Parent other than the MFC Parent

Treatment	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Exp. Date: Treatment/Therapy:																																
Instructions:																																
Times per Day:																																
Exp. Date: Treatment/Therapy:																																
Instructions:																																
Times per Day:																																
Exp. Date: Treatment/Therapy:																																
Instructions:																																
Times per Day:																																
Exp. Date: Treatment/Therapy:																																
Instructions:																																
Times per Day:																																

Initials: ____ Signature: ________________________ Initials: ____ Signature: ________________________ Initials: ____ Signature: ________________________

Comments: ____

This page intentionally left blank

ATTACHMENT XXII Medical Foster Care Child Placement Log

Administrative Record

Medical Home______________________________________

(List all children residing in the home including birth, adoptive, relative, foster, friend)

Name	DOB	Sex	Minority yes/no	Placement Date	Discharge Date	Discharge Destination	MFC yes/no

Page ____ of ____

This page intentionally left blank