Policy Subject:	Qualified Residential Treatment Program (QRTP) and other IV-E Reimbursable Non-Family Based Placement Settings
Effective Date:	July 1, 2022
Approved By:	Denise Conway, LCSW-C Executive Director Social Services Administration (SSA)
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Originating Office:	Placement and Permanency Unit
Supersedes:	SSA/CW 20-06 Qualified Residential Treatment Program (QRTP) and other IV-E Reimbursable Non-Family Based Placement Settings
Program Affected:	Placement and Permanency SSA; LDSS Placement & Permanency Units; Private Providers with DHS Contracts; Title IV-E

Legal Information & Purpose:
Maryland Department of Human Services/Social Services Administration (DHS/SSA) has maintained a long-standing commitment to keeping children and families together, beginning with Place Matters in Fiscal Year 2008 followed by Families Blossom and most recently through our Integrated Practice Model (IPM). The Family First Prevention Services Act (Family First), signed into law on February 9, 2018, creates historic reforms to help children remain safely with their families or in home-based settings when out of home care is absolutely necessary.

This policy outlines the Family First provision for the placement of a child in a Qualified Residential Treatment Program (QRTP) and other IV-E reimbursable non-family based placement settings. A QRTP placement is a specific category of a non-resource (foster) family home setting, for which title IV-E agencies must meet detailed assessment, case planning, documentation, judicial determination and ongoing review and permanency hearing requirements for a child to be placed in and continue to receive title IV-E foster care maintenance payments (FCMPs) for the placement (sections 472(k)(l)(B) and 475A(c) of the Social Security Act). The Maryland legislature passed SB1043 during the 2019 legislative session for Maryland to be in compliance with the judicial determination requirements of the QRTP provisions of Family First. The pertinent statutory provisions can be found in sections 3-801 and 3-816.2 in the Courts & Judicial Proceedings Article of the Annotated Code of Maryland. Finally, as described in section 472(k)(2) of the Act, if the child care institution (CCI) is one of the non-family based placement settings outlined in section 6 of this policy, title IV-E FCMPs may continue after 14 days if the setting meets all requirements specified in statute and policy.

The limitations on placement settings described in this policy apply to new placements made on or after October 1, 2019. Title IV-E agencies may claim title IV-E FCMPs for children placed in a childcare institution (CCI) prior to October 1, 2019 for as long as the eligible child continuously remains in that placement setting. If the child later leaves the placement setting and enters a different non-family based placement setting, the title IV-E agency must apply the guidelines in this policy.

Policy:
The purpose of this policy is to outline the specific requirements and actions required of the Local Departments of Social Services (LDSS) and childcare institutions with a QRTP and the other non-family based placement settings to comply with Family First. The procedural guidance section will focus on the following areas:

1. QRTP Facility Designation
2. Qualifications and Training of the Qualified Individual
3. QRTP Assessment Process and Tool
4. QRTP Court Review
5. Ongoing QRTP Placement Requirements
6. IV-E Reimbursable Non-Family Based Placement Settings
    a. QRTP
    b. a setting specializing in providing prenatal, post-partum, or parenting supports for youth
    c. a setting providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming, sex trafficking victims

d. a supervised setting in which the child is living independently
e. a placement for a child placed with a parent in a licensed residential family-based treatment facility for substance abuse

7. Limitation on Federal Financial Participation

Procedural Guidance

1. QRTP Facility Designation

A QRTP placement is a specific category of a non-family based placement setting that is a CCI as is defined, in relevant part, as "a private child-care institution, or a public childcare institution which accommodates no more than 25 children, which is licensed by the State in which it is situated or has been approved by the agency of the State responsible for licensing or approval of institutions of this type as meeting the standards established for the licensing." (See section 472(c)(2)(A) and (C) of the Act). Under title IV-E, a QRTP must meet the following criteria:

- Provides a trauma-informed model of care designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances as identified in the required 30-day assessment facilitated by the LDSS Qualified Individual (see below in Section 2).
- Has registered or licensed nursing staff and other licensed clinical staff who provide care within the scope of their practice as defined by state law, who are on-site consistent with the treatment model, and who are available 24 hours/7 days a week (need not solely be direct employees of the QRTP).
- Facilitates family participation in a child's treatment program (to the extent appropriate, and in accordance with the child's best interest).
- Facilitates and documents family outreach and maintains contact information for any known biological family and fictive kin of the child.
- Documents how the child's family is integrated into the child's treatment, including post discharge, and how sibling connections are maintained.
- Provides discharge planning and family-based aftercare supports for at least 6 months post discharge; and
- The program is licensed in accordance with title IV-E requirements and nationally accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Healthcare Organizations (the Joint Commission), the Council on Accreditation (COA), or another independent, not-for profit accrediting organization approved by the Secretary of the U.S. Department of Health and Human Services. NOTE: Two additional accrediting organizations have been approved by the Secretary: Educational Assessment Guidelines Leading toward Excellence (EAGLE) and Teaching-Family Association.

DHS will identify and certify childcare institutions that meet all of these QRTP requirements.

NOTE: There are differences between a QRTP and a Psychiatric Residential Treatment Facility (PRTF), also known as Residential Treatment Centers (RTC). It is important to note that RTCs are facilities that require medical necessity and a Certification of Need (CON) in order to refer and place a child. Also, important to note is that RTCs are paid for by Medical Assistance and, therefore, are not IV-E reimbursable settings. (See Related Information Section.)

2. Qualifications and Training of the Qualified Individual

Family First requires the use of a "Qualified Individual" (QI) to conduct an assessment that determines the clinical appropriateness for QRTP placement and for purposes of approving the case plan and the case system review process. A QI is a trained professional or licensed clinician who will maintain objectivity with respect to determining the most effective and appropriate placement for a child. The QI can be an employee of the State of Maryland or any Maryland LDSS based on the below criteria. DHS/SSA has requested a waiver related to who can serve in this role allowing for the QI to be an employee of DHS or any Maryland LDSS. The QI cannot be an employee of a private placement provider for children in the care of the State.

Qualifications:

DHS/SSA will designate the QI for each LDSS or LDSSs designated as a Region.

Each LDSS, or Region, will identify the professional who will serve in the QI role. The LDSS or Region must demonstrate that the identified professional meets all of the below qualifications by submitting the individual's name and qualifications with their LDSS Director's, or designee's, approval to the SSA Placement and Permanency Unit. The QI must meet the following professional qualifications:

- Maryland licensed clinician who has completed statutorily required Child Welfare Competency Training with at least 3 years of casework and/or supervisory experience in child welfare. QI must meet the state requirements of licensure or certification of their professional designation (i.e., licensed behavioral health clinician, psychologist or licensed social worker or licensed professional counselor).
- Has no direct case management responsibility or placement authority for a child's case under their review to ensure objectivity.
- Will work in conjunction with the child's permanency team; and
- Has successfully completed QRTP Qualified Individual Training (see below) as evidenced by a certificate of completion.

Training:

In addition to the professional requirements mentioned above, the QI must also maintain current certification in the Child and Adolescent Needs & Strengths (CANS) assessment tool (1 day of training, including key principle and rating guidelines, item review and practice certification test, and CANS Certified with a reliability score of .70 or higher), as well as successfully complete the QRTP training as evidenced by a certificate of completion. The QRTP training will include:

- Skill development related to the placement referral and assessment process, including the assessment forms (i.e., Placement Request form and QRTP 30-day assessment).
- Family and child engagement and family teaming practices.
- Clinical assessment skills related to making a level of care determination.
- Court processes; and
- Service identification and service array.

SSA will ensure that QRTP Qualified Individual training sessions are offered routinely and that QIs receive notice of these offered trainings, as they are made available. Ongoing learning opportunities for QIs will also be made available.

3. QRTP Referral and Assessment Process and Tool

All placement decisions for children in need of an out-of-home placement are based on the child or youth's clinical needs and determined in collaboration with the youth's family through a *comprehensive and collaborative assessment* process utilizing the CANS, an age-appropriate, evidence-based, validated, functional assessment tool, as described in the CANS Manual. When the child's caseworker and supervisor are considering a QRTP placement, they are to make a referral to the QI using the clinically focused, trauma responsive Placement Request Form, Parts 1 and 2 (Attachment A), and required supporting documentation. The QI begins the assessment by reviewing the Placement Request Form and the attachments. The QI then schedules a QRTP Planning Meeting. See Teaming Policy for composition of the QRTP Planning team.

QRTP Planning Meetings (removal or placement changes) are convened by a facilitator. The QI may serve as the facilitator or as a member of the placement decision-making team. At the QRTP Planning Meeting, the QI works collaboratively with the family and the QRTP Planning team to complete the assessment by ensuring that the team addresses the QRTP Assessment Form (Attachment B) questions that require discussion and documentation of the following:

- Reason for Placement/Change in Placement and Child/Family Perceptions/Feelings/Attitudes toward placement
- Current Mental Health Services/Narrative
- Placement Recommendations, including goals and service needs
- Justification of Least Restrictive Placement when a non-family based placement setting is being recommended

If the QI concludes that the child's needs do not warrant a non-family based placement setting because they can be met within a family-based setting, the QI indicates this decision on the QRTP Assessment Form (Attachment B) and describes the goals and service recommendations for the family-based placement type. If the child has already been placed in a QRTP, the child must be transitioned out of the QRTP within 30 days.

When the QI, with the team's input, concludes that the child's current clinical needs cannot be met in a family member's, a resource (foster) family's home, or another non-family based placement setting identified in Section 6, the QI completes the addendum to Attachment B (QRTP Assessment Form) by documenting the following:

- The needs of the child cannot be met with family members or through placement in a resource (foster) family home because the family is unable or unwilling to provide for the needs of the child and placement in a resource (foster) family home is contrary to the welfare of the child and public safety,
- All other non-family based placement settings identified in Section 6 have been ruled out, AND
- A QRTP is the setting which will provide the most effective and appropriate level of care for the child in the least restrictive environment and will be consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child. (Section 475A(c)(1)(A) and (C) of the Act).
- The placement preferences of the family and permanency team relative to the assessment that recognizes children should be placed with their siblings unless there is a finding by the court that such placement is contrary to their best interest; and

- If the placement preferences of the family and permanency team and child are not the placement setting recommended by the QI conducting the assessment, the reasons why the preferences of the team and of the child were not recommended.

NOTE: A shortage or lack of resource family homes shall not be an acceptable reason for determining that the needs of the child cannot be met in a foster family home.

Next, the QI, with the team's input, determines which QRTPs will provide the most effective and appropriate level of care for the child in the least restrictive environment. The selected setting must also be consistent with the team's short and long-term mental and behavioral health goals for the child. When sending the Placement Request Form (Attachment A), the QRTP Assessment Form and Addendum (Attachment B) must also be submitted and included in the child's case plan for approval.

This assessment and approval process must be completed prior to the child's placement. In cases where this is not possible, the assessment must be completed within 30 days of the placement. If the assessment is not completed within 30-days after placement, no Federal payments shall be made for any amounts expended for FCMP on behalf of the child during the placement.

4. QRTP Court Review

Another required step separate from the QI's assessment and approval of the QRTP placement is the Court Review. The QI's assessment and the LDSS's documents justifying the QRTP placement must be reviewed by the court within 60 days of the start of each placement in a QRTP and every six months thereafter.

At the initial hearing, the court must:

1. Review the assessment of the child conducted by the QI, the determination of the child placement recommendation and any supporting documentation.
2. Determine whether the needs of the child can be met through placement in a resource (foster) family home, and, if not, whether placement of the child in a QRTP provides the most effective and appropriate level of care for the child in the least restrictive environment.
3. Determine whether a QRTP placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child; and
4. Based on items above, provide written documentation of the reasons for its decision to approve or disapprove the continued placement of the child in a QRTP.

At each six-month status review and each permanency hearing the court must:

1. Determine whether ongoing assessment of the strengths and needs of the child continues to
2. support the continued placement of the child in a QRTP, and determine whether the needs of the child cannot be met through placement in a resource family home,
3. Determine whether the placement in a QRTP continues to provide the most effective and appropriate level of care for the child in the least restrictive environment,
4. Determine whether the placement continues to be consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child.
5. Determine the specific treatment or service needs that will be met for the child in the placement and the length of time the child is expected to need the treatment or services.

6. Determine the efforts made by the State agency to prepare the child to return home or to be placed with a fit and willing relative, a legal guardian, or an adoptive parent, or in a foster family home.

If the court disapproves the QRTP placement at the initial hearing, six-month review, or permanency review, the child must be stepped up or down to a placement that is better able to address the child's needs within 30 days of the court's decision. The caseworker must document the court's decision in the child's case plan. Although a change in placement may take longer than 30-days, no FCMP shall be claimed after 30-days of a decision that QRTP is no longer appropriate.

The caseworker must provide the supporting documentation to the court for review at each hearing and document the court's decision in the child's case plan.

Note: Item #5 is not on the list of requirements for the court at the initial 60-day hearing.

5. Ongoing QRTP Placement Requirements

Once a child is placed in a QRTP, the LDSS, in collaboration with the child, family, and treatment team, convenes ongoing (e.g., no less than quarterly) QRTP Planning Meetings to assess and monitor the child's continued progress and readiness for discharge. The LDSS determines the composition and frequency of these meetings jointly with the family, treatment team, and direct input from the child (unless clinically contra-indicated).

The caseworker must document this ongoing assessment in the child's case plan including the following information:

- How the caregiver is meeting the child's needs as well as the appropriateness and restrictiveness of the placement; and
- Explanation of any changes in the child's placement during the past 6 months and discussion about any anticipated changes in the child's placement in the next 6 months.

The LDSS is required to submit evidence of the child's continued clinical need for a QRTP at each 6-month status review and 12-month permanency hearing as long as the child remains in a QRTP. At these hearings, the LDSS must provide written documentation demonstrating that:

- The ongoing assessment (CANS) of the child's strengths and needs continues to support the determination that the child's needs cannot be met in the family or a foster family home; AND
- That placement in a QRTP provides the most effective and appropriate level of care in the least restrictive environment; AND
- That the placement is consistent with the child's short and long-term mental and behavioral health goals as specified in the permanency plan.

The written justification must also include:

- The specific treatment or service needs that will be met for the child in the placement, and the length of time the child is expected to need the treatment or services, and
- Efforts made by the LDSS and the treatment agency to prepare the child and family for the child's return home or to be placed with a fit and willing relative, legal guardian, or an adoptive parent or resource (foster) family home (section 475A(c)(4) of the Act).

Family First requires additional documentation when a child remains in a QRTP for an extended duration. When the child is in a QRTP for 12 consecutive or 18 non-consecutive months (or in the case of a child who has not attained age 13, for more than 6 consecutive months or non-consecutive months), the LDSS permanency case management team will submit to SSA the most recent evidence specified at the most recent permanency or status hearing and documentation supporting the continued need for placement. This evidence and documentation must contain the LDSS Director's signature and must be submitted for signed approval by the DHS Secretary or his/her designee for the continued placement of the child in that setting.

6. IV-E Reimbursable Non-Family Based Settings

Title IV-E foster care maintenance payments (FCMP) may continue on behalf of an otherwise eligible child after 14 days if the eligible child is in a CCI placement that is one of the following:

A. QRTP as described in Sections 1and 3-5 above
B. A placement setting specializing in providing prenatal, post-partum, or parenting support for youth must meet the definition of a CCI at sections 472(c)(2)(A) and (C) of the Act. It must also meet the standards established in COMAR 14.31.07.10 and 14.31.07.11, specialized licensing standards for Residential Child Care (RCC) facilities that care for Pregnant Adolescents and Mother-Infant Group Homes
C. A placement for a child placed with a parent in a licensed residential family-based treatment facility for substance abuse for up to 12 months in accordance with requirements in sections 472(j) and 472(a)(2)(C) of the Act and Child Welfare Policy 19-8.
D. A supervised setting for a child who has reached the age of 18 and is living independently. The caseworker and supervisor should ensure that the standards in COMAR 07.05.04 Private Independent Living Program as well as the Ready By 21 Manual Semi-Independent Living Arrangement guidelines are followed.
E. A setting providing high quality residential care and supportive services to children and youth who have been found to be or are at risk of becoming sex trafficking victims in accordance with section 471(a)(9)(C) of the Act. Residential childcare providers serving youth who have been found to be, or are at-risk to be sex trafficking victims, must demonstrate in their policies and procedures an understanding of the trauma and the possible behavioral symptoms, should the trauma go untreated (e.g., anti-social behaviors that limit their ability to live, work, and engage in prosocial activities). CCI's that serve this population must meet the following criteria to be considered to provide "high quality residential care" and "supportive services":
    - Provide ongoing intensive services to youth (male, female and/or transgendered) who have experienced sexual abuse due to sex trafficking.
    - House and care for no more than 3 to 4 youth in this population in one setting with one youth per bedroom.
    - Provide on-site counseling services and appropriate therapeutic modalities necessary to meet the needs of the children in care.
    - Ensure that each school-aged child attends an educational or vocational program in accordance with all applicable federal, State, and local laws.
    - Have the ability to provide high intensity group home services in a campus-type or community-based facility.

- Offer a trauma informed treatment practice, providing individual trauma therapy, group therapy with a focus on commercially sexually exploited children (CSEC) and victim advocacy; and
- Ensure a minimum resident to staff ratio (excluding volunteers and staff not providing direct care and supervision of residents) of 2:1 during waking hours and 8:2 during sleeping hours.

The LDSS caseworker and supervisor should follow SSA/CW #18-10 Identification, Reporting, Management and Training Related to Sex Trafficking Victims. This policy directs them to use the Child Sex Trafficking Screening Tool to assess for risk.

7. Limitation on Federal Financial Participation

After 14 days in a CCI placement, Title IV-E foster care maintenance payments may not be claimed or made on behalf of an otherwise eligible child unless the child is placed in a setting specified in Section 6 of this policy.

For a child placed in one of the settings described in section 6 of this policy, the State may claim administrative costs for the duration of the placement regardless of whether the placement requirements (e.g., assessment, documentation, and judicial determination requirements for placement) are met. However, if the requirements are not met, only administrative costs as defined in 45 CFR 1356.60(c) for the administration of the Title IV-E program are allowed while the costs of the administration and operation of the QRTP are not allowed.

Alignment with Practice Model and Desired Outcomes

This policy supports the goal of the Integrated Practice Model to engage in a collaborative assessment process that is trauma-informed, culturally responsive, and inclusive of formal and informal community partners. It emphasizes an approach that is family-centered, individualized, and outcomes-driven.

Forms

- ❏ Placement Request Form (Attachment A)
- ❏ QRTP Assessment Form and Addendum (Attachment B)

Related Information

SSA/CW #12-14 – Maryland Child and Adolescent Needs and Strengths Assessments
SSA/CW #19-8 - Child placed with parent in Substance Use Treatment Facility
SSA/CW #20-05 - Placement Referral Process Policy
SSA/CW #21-02 – Family Teaming
Family First Prevention Services Act
Building Bridges Comparison of QRTP and PRTF (aka RTC): https://www.familyfirstact.org/sites/default/files/BBI%20QRTPPRTF%20Comparison%20Document%20-%20Final.pdf
Center for Medicaid Services FAQ Guidance: https://www.medicaid.gov/federal-policyguidance/downloads/faq092019.pdf

ATTACHMENT A

PLACEMENT REFERRAL FORM

(To be completed by Caseworker and Approved by Supervisor. If requesting a QRTP placement, submit this COMPLETED DOCUMENT with required supporting documentation to the Qualified Individual/QI)

Part I: Background and Demographic Information

YOUTH INFORMATION					
Youth's Name: Click here to enter text.		**CJAMS ID#:** Click here to enter text.	**DOB:** Click here to enter a date.	**Age:** Click here to enter text.	
Gender: (Check All that Apply) ☐ **Male** ☐ **Female** ☐ **Non-Binary** ☐ **Transgender Female** ☐ **Transgender Male** ☐ **Other**		**Preferred Pronoun:** ☐ **Male (he/him/his)** ☐ **Female (she/her(s))** ☐ **They/Them** ☐ **Other** Please specify Click here to enter text.			
Weight: Enter weight	**Height:** Enter height	**Race/Ethnicity:** ☐ African American (Black) ☐ American Indian or Alaskan Native, specify tribe ☐ Asian or Asian-American ☐ Caucasian (White) ☐ Hispanic or Latino(a) American ☐ Native Hawaiian or Other Pacific Islander ☐ Other			
Preferred Language: Choose an item.	**Legal Status**: Choose an item.		**If in Care, Permanency Goal:** Enter Permanency Goal		
Immigration Status:	Choose an item.				
Special Considerations:	Enter text				
Deaf & HOH: ☐	LGBTQ: ☐	DD/IQ ☐	Substance Abuse: ☐	DV: ☐	Trafficking Victim ☐
Sexual Abuse Victim: ☐	Sexual Abuse Offender: ☐	Pregnant & Parenting: ☐	Other issues: Click here to enter text.		

YOUTH LIVING SITUATION				
Where is youth currently living?	Home of Parent or Legal Guardian	Foster Placement, Type Enter placement type.	Shelter	Detention/DOC
Other Click here to enter text.	Psychiatric Hospital	Medical Hospital	Homeless	Friend or Relative
Name of Contact Person or Facility:				
Address:		**City:**	**Zip Code:**	
Describe any prior DSS History/Services (Include dates and reasons for involvement):				

YOUTH LIVING SITUATION				
Click here to enter text.				
For Youth Already in Care:				
Current Placement Date:			**Date First Entered Care:**	
Name of Parent/Legal Guardian	Click here to enter text.		**Phone #:**	
	Relationship to youth: Click here to enter text.			
	Address:	Click here to enter text.		
Name of Parent/Legal Guardian:	Click here to enter text.		**Phone #:**	
	Relationship to youth: Click here to enter text.			
	Address:	Click here to enter text.		

PLACEMENT REQUEST INFORMATION		
Date of Request:	**Date Placement Needed:**	
	Emergency Placement: Yes ☐ **No** ☐	
Referring Worker Name:	**Phone #:** Click here to enter text.	**Email:**
Supervisor Name: Click here to enter text.	**Phone #:** Click here to enter text.	**Email:** Click here to enter text.
Was a Family Team Decision Meeting Completed in conjunction with this referral? Yes ☐ **No** ☐	**If NO, provide an explanation why?** Click here to enter text. **Date FTDM scheduled to occur?** Click here to enter text.	
Type of Placement Requested (Level of Care): Choose an item. Please attach any applicable identifying information on non-committed youth to this form.	**Date of Last Family Team Meeting (e.g., FTDM) if applicable**: Enter Date	

REASON FOR PLACEMENT OR CHANGE IN PLACEMENT	
Enter the reason for seeking a placement or placement change at this time:	
Click here to enter text.	
Is current caregiver able/willing to keep involved with the youth?	Yes ☐ No ☐ IF YES, clarify whether for phone contact, visitation, participation in treatment, and/or as resource for return post congregate care stay.

	Click here to enter text.
Review Youth Functioning – CANS (Section II)	Discuss the current identified strengths and needs. Is the team in agreement with the scoring? What services or actions are needed?

CURRENT PLACEMENT INFORMATION
Describe the youth's feelings/perceptions about the change in living situation:
Click here to enter text.
Describe the youth's attitude toward, and/or involvement in, the placement being proposed:
Click here to enter text.
Describe the parent's attitude toward the placement being proposed and willingness for continuing involvement:
Click here to enter text.
Describe family of origin's involvement with the youth:
Click here to enter text.
Describe the current visitation plan:

REQUIRED DOCUMENTS TO SUPPORT PLACEMENT REQUEST (Please attach all required documents to this referral form – Clarify if PENDING)
Child and Adolescent Needs and Strengths (CANS) Assessment (most recent)
Psychosocial History
Youth's Placement History, if applicable
Psychological Evaluations (most recent) – if one has been done
School records (e.g., IEP, etc.)
Treatment reports
Counseling or therapy report, most recent – if applicable
Psychiatric Assessment with treatment plan (most recent)
Hospital Discharge Reports (within last 12 months), if applicable
Certificate of Need – include medical (for RTC referrals)
Others (Please Specify): Click here to enter text.

YOUTH'S FAMILY COMPOSITION					
	Mother LG ☐ CC ☐	Father LG ☐ CC ☐	Legal Guardian (LG) *(if not mother or father)*	CJAMS Head of Household *(If not mother or father)*	Other (e.g., Spouse/Partner)
Name	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
CJAMS #					
DOB	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
SSN					
Phone					
Address	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

ATTACHMENT A

YOUTH'S SIBLINGS (use additional page if needed)				
	Sibling	**Sibling**	**Sibling**	**Sibling**
Name	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
DOB	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
Who is Sibling Living with Currently?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Consider Placement with Sibling? (Y/N)	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Invite to Team Meeting (e.g., FTDM, QRTP Planning Meeting)	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Address	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

OTHER RELATIVES/FRIENDS/NATURAL SUPPORTS (List once for all children)				
Name	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Relationship to Youth	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Address	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Phone #				
Invite to Team Meeting (e.g., FTDM, QRTP Planning Meeting)	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Transport Needed?	Choose an item.	Choose an item.	Choose an item.	Choose an item.

OTHER INTERESTED PARTIES (Including but not limited to: school, therapist, child's attorney, DJS worker, CASA, etc.)				
Name	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Relationship to Youth	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Address	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Phone #	Click here to enter text.			
Invite to Team Meeting (e.g., FTDM, QRTP Planning Meeting)	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

Part II: Youth Functioning (Please attach any relevant information)

EDUCATION & VOCATION					
Is youth currently attending an educational or vocational program?				**Yes** ☐ **No** ☐	
IF No, date last attended:	Click here to enter a date.			**Grade Last Completed:**	Click here to enter text.
Name of Current School/Alternative School: Click here to enter text.					
Grade Level:	Click here to enter text.	**IEP?**	**Yes** ☐ **No** ☐	**Date of Next IEP Meeting:**	Click here to enter a date.
Name of Parent Surrogate:					
Click here to enter text.					
School Recommendations, if any:					
Click here to enter text.					
Describe how youth has been doing in school during last 90 days:					
Click here to enter text.					

EMPLOYMENT			
Is youth currently employed?		**Yes** ☐ **No** ☐	
Name of employer:	Click here to enter text.	**Date Last Employed:**	Click here to enter a date.
Describe how youth has been doing at work during last 90 days:			
Click here to enter text.			

LEGAL				
Check If:		**Upcoming Court Dates**	**Charges**	**Status of Charges**
☐	**DJS Involved**			
☐	**Gang Involved**			
☐	**Electronic Monitoring**			
☐	**DJS Committed/Co-Committed**			

PHYSICAL – MEDICAL INFORMATION (e.g., chronic and acute conditions, such as asthma, allergies, diabetes, STDs, medical and physical disabilities, pregnancy, etc.)						
Does Youth have a Primary Care Physician?				**Yes** ☐ **No** ☐		
Name of Primary Care Physician:	Click here to enter text.			**Date Last Seen:**	Click here to enter a date.	
Does Youth have a Dentist?				**Yes** ☐ **No** ☐		
Name of Dentist:	Click here to enter text.			**Date Last Seen:**	Click here to enter a date.	
Phone #:	Click here to enter text.	**Private Insurance**	**Yes** ☐ **No** ☐			
Medical Condition (Diagnosis)	**Specialist Name**	**Phone/Email**	**Current Medications (if applicable)**	**Dose/Frequency (if applicable)**	**Medication is currently available**	**Youth is taking medication as prescribed**

					Yes ☐ No ☐	Yes ☐ No ☐
					Yes ☐ No ☐	Yes ☐ No ☐
					Yes ☐ No ☐	Yes ☐ No ☐
					Yes ☐ No ☐	Yes ☐ No ☐
					Yes ☐ No ☐	Yes ☐ No ☐

Is the youth currently pregnant?	**Yes** ☐ **No** ☐
Does the youth require any special equipment for their medical condition or diagnosis?	**Yes** ☐ **No** ☐
Describe:	
Click here to enter text.	
Has the youth ever been hospitalized for a medical condition?	Choose an item.

Hospital Name	**Admission Date**	**Discharge Date**	**Discharge Diagnoses**

MENTAL & BEHAVIORAL HEALTH INFORMATION

Does youth have a current therapist or counselor?			**Yes** ☐ **No** ☐
Name:	Click here to enter text.	**Date Last Seen:**	Click here to enter a date.
Phone #:	Click here to enter text.	**Private Insurance**	**Yes** ☐ **No** ☐
Reason for Treatment:	Click here to enter text.		
Current Diagnoses from Provider:	Click here to enter text.		

Is youth cooperative with therapy?	**Yes** ☐ **No** ☐
If NO, please explain:	Click here to enter text.
Has the youth had a psychological evaluation within the last two (2) years? (If YES, please attach psychological evaluation to this form)	**Yes** ☐ **No** ☐
Is youth currently prescribed medications?	**Yes** ☐ **No** ☐ IF **YES**, complete additional medication information

Medication Name	**Reason for medication**	**Name of prescriber**	**Dose/Frequency (if applicable)**	**Medication is currently available**	**Youth is taking medication as prescribed**
				Yes ☐ **No** ☐	**Yes** ☐ **No** ☐
				Yes ☐ **No** ☐	**Yes** ☐ **No** ☐
				Yes ☐ **No** ☐	**Yes** ☐ **No** ☐
				Yes ☐ **No** ☐	**Yes** ☐ **No** ☐

MENTAL & BEHAVIORAL HEALTH INFORMATION					
				Yes ☐ No ☐	Yes ☐ No ☐

Has youth been in outpatient therapy or counseling before?	**Yes** ☐ **No** ☐
What was the outcome of therapy?	Click here to enter text.
Describe: Click here to enter text.	
Has the youth ever been hospitalized for a mental health or psychiatric condition?	Choose an item.

Hospital Name	Admission Date	Discharge Date	Discharge Diagnosis

PLACEMENT & SERVICES RECOMMENDATIONS:
(Please include recommended level of service intensity and supports needed)

Decision(s) Made and why (Consider the youth's strengths and needs):
Click here to enter text.

Recommended Placement Type Needed and why. NOTE: If family is not in agreement, why were their preferences not recommended and what is the justification for the recommendation? If the child has a sibling in care, what considerations were made around placing the child with his/her siblings or was there any finding by the court that such placement is contrary to the child's best interest**?** Click here to enter text.

LIST Child or youth's specific short- and long-term mental and behavioral health goals:

1. Click here to enter text.
2. Click here to enter text.
3. Click here to enter text.
4. Click here to enter text.
5. Click here to enter text.

LIST Service Recommendations:

1. Click here to enter text.
2. Click here to enter text.

Are the youth, family members and identified caregiver(s) in agreement and willing to support this decision?

Yes ☐ **No** ☐ Click here to enter text.

Describe your INTERIM PLAN for stabilizing the youth's current placement while awaiting the needed level of care:

Click here to enter text.

Are BOTH the youth and current caregiver willing to support this plan? Yes ☐ **No** ☐

IF NO, please explain:

Click here to enter text.

ATTACHMENT A

Justification of Least Restrictive Placement
When a non-family based setting, placement is recommended (i.e., not kinship, regular foster care or treatment foster care), please provide the following additional information: 1. Exploration of all other resources including kin/relatives, family foster home, and treatment foster home and the specific reasons they each were determined to be inappropriate: 2. Facts that illustrate the child's need for supervision and therapeutic intervention which cannot be provided in a family setting and why wraparound/support services are not available in the family setting or would not be enough to meet the needs of the child: 3. All other supervision and service options that have been explored and an explanation of why it has been determined that these supervisory supports and services cannot be provided in a family setting: 4. Whether the recommendation for a non-family setting emanated from a family meeting and any information that supports that decision
I certify that a **Family Team Decision Meeting** was conducted on _____ (date of FTDM), which included the child's family and permanency team, and that I have made the following determination: (Choose one) ☐ The child's current clinical needs cannot be met in a family member's, a resource (foster) family's home, or another non-family based placement setting because the needs of the child cannot be met with family members or through placement in a foster family home because the family is unable or unwilling to control the child's behavior and placement in a foster family home is contrary to the welfare of the child and public safety

AUTHORIZED SIGNATURES
SIGNATURE OF WORKER (or PERSON) SUBMITTING THIS FORM: **WORKER PRINTED NAME:**
TITLE:
PHONE #:
EMAIL:
SIGNATURE OF SUPERVISOR:
SUPERVISOR PRINTED NAME:
SUPERVISOR PHONE #:
SUPERVISOR EMAIL:

PLACEMENT REQUEST FORM - KEY

PLACEMENT TYPE:

Formal Kinship Care
Restrictive Kinship Care
Public Resource (Foster) Home
Treatment Foster Care
Medically Fragile TFC
*Mother baby (TFC or Group)
Diagnostic
Respite
Regular Group Home
Therapeutic Group Home
Medically Fragile Group
Residential Treatment Center
Alternative Living Unit
Independent Living

RACE/ETHNICITY:

African American (Black)
American Indian or Alaskan Native, specify tribe
Asian or Asian-American
Caucasian (White)
Hispanic or Latino(a) American
Native Hawaiian or Other Pacific Islander
Other

ATTACHMENT B

PLACEMENT REFERRAL FORM
QUALIFIED INDIVIDUAL – QRTP ASSESSMENT FORM
(To be completed by the Qualified Individual (QI) in conjunction with the youth and youth's Facilitated Team Decision Meeting and returned with the completed Placement Request Form (Attachment A) to the assigned LDSS worker)

YOUTH INFORMATION			
Youth's Name: Click here to enter text.	**CJAMS ID#:** Click here to enter text.	**DOB:** Click here to enter a date.	**Age:** Click here to enter text.
Gender: (Check All that Apply) ☐ **Male** ☐ **Female** ☐ **Non-Binary** ☐ **Transgender Female** ☐ **Transgender Male** ☐ **Other**	**Preferred Pronoun:** ☐ **Male (he/him/his)** ☐ **Female (she/her(s))** ☐ **They/Them** ☐ **Other** Please specify Click here to enter text.		

LOCATION OF YOUTH AT ASSESSMENT				

QUALIFIED INDIVIDUAL		
Name of QUALIFIED INDIVIDUAL (QI)	**LDSS/Office Location:**	**Phone #:** **Email:**

ASSESSMENT INFORMATION		
☐ **Initial**	Date Assessment Began:	Date Assessment Complete:
☐ **Re-Assessment for Continued need of QRTP**	Date Assessment Began:	Date Assessment Complete:

DOCUMENTATION-INFORMATION GATHERING
In addition to the required documentation in Part A, list any additional records, reports or collateral information you reviewed to make your determination:

INTERVIEWS (CHILD, FAMILY, SUPPORTS, TREATMENT PROVIDERS, ETC.) Add more rows as needed.			
Name	**Date of Interview**	**Relation to Child**	**Interview Status**

			☐ **Attempted** ☐ **Completed**
			☐ **Attempted** ☐ **Completed**
			☐ **Attempted** ☐ **Completed**
			☐ **Attempted** ☐ **Completed**

CURRENT MENTAL HEALTH ASSESSMENT

Has the youth received counseling or mental health therapy within the past 90 days for any of the behaviors or symptoms endorsed above? (ATTACH A RECENT REPORT FROM PROVIDER) Yes ☐ No ☐

Have additional supports been recommended to address the youth's needs? If Yes, please describe:

Yes ☐ No ☐

Review Youth Functioning and Summarize Findings – CANS (Discuss the current identified strengths and needs.

Any factors that you might consider important as to why the youth might need a higher level of care than recommended by the CANS:

- ☐ Severe Substance Abuse
- ☐ Complex Medical Needs
- ☐ Complex Developmental Needs
- ☐ Complex Mental Health Needs
- ☐ Available Community Resources Have been unsuccessful
- ☐ Other (Describe Below)

Any factors that you might consider important as to why the youth might be successful in a lower level of care than recommended by the CANS:

- ☐ Child Strengths
- ☐ Caregiver Strengths
- ☐ Community Resources Available
- ☐ Caregiver Resources Available
- ☐ Treatment Foster Care
- ☐ Other Type of Approved Non-Family Based Placement (e.g., Independent Living, etc.)

CURRENT MENTAL HEALTH ASSESSMENT
☐ Other (Describe Below)
Is the youth, family and/or team in agreement with the scoring? Yes ☐ No ☐ **If no, document discrepancies with explanation:**
Describe Needed Supports from QI Assessment to meet the youth's needs (What services or actions are needed?)**:** Click here to enter text.

PLACEMENT-RELATED INFORMATION
Describe the youth's feelings/perceptions about the change in living situation:
Click here to enter text.
Describe the youth's attitude toward, and/or involvement in, the placement being proposed:
Click here to enter text.
Describe the parent's attitude toward the placement being proposed and willingness for continuing involvement:
Click here to enter text.
Describe family of origin's involvement with the youth:
Click here to enter text.
Describe the current visitation plan:

PLACEMENT & SERVICES RECOMMENDATIONS: (Please include recommended level of service intensity and supports needed) ***NOTE: To be completed by the Qualified Individual (QI) in conjunction with the FTDM**	
Decision(s) Made and why (Consider the youth's strengths and needs)**:** Click here to enter text.	
Identify factors that were considered in your decision (This can include but is not limited to: reason for placement and/or placement history, child strengths, child's trauma history, risk behaviors, community supports, and/or youth or family preference)**:**	
QRTP Recommended: ☐	**QRTP NOT Recommended:** ☐
If not QRTP, Recommended Placement Type needed and why. Click here to enter text.	
LIST Child or youth's specific short- and long-term mental and behavioral health goals:	

1. Click here to enter text.
2. Click here to enter text.
3. Click here to enter text.
4. Click here to enter text.
5. Click here to enter text.

LIST Service Recommendations:

1. Click here to enter text.
2. Click here to enter text.

Are the youth, family members and identified caregiver(s) in agreement and willing to support this decision?
NOTE: If family is not in agreement, why were their preferences not recommended and what is the justification for the recommendation?

Yes ☐ **No** ☐ Click here to enter text.

Describe your INTERIM PLAN for stabilizing the youth's current placement while awaiting the needed level of care:

Click here to enter text.

Are BOTH the youth and current caregiver willing to support this plan? Yes ☐ **No** ☐

IF NO, please explain:

Click here to enter text.

QRTP Assessment Addendum
(To be Completed by the Qualified Individual following the FTDM Meeting)

Justification of Least Restrictive Placement

When a QRTP is recommended, please provide the following additional information:

1. Exploration of all other resources including kin/relatives, family foster home, and treatment foster home and the specific reasons they each were determined to be inappropriate.

2. Facts that illustrate the child's need for supervision and therapeutic intervention which cannot be provided in a family setting and why wraparound/support services are not available in the family setting or would not be enough to meet the needs of the child:

3. All other supervision and service options that have been explored and an explanation of why it has been determined that these supervisory supports and services cannot be provided in a family setting:

4. Whether the recommendation for a QRTP setting emanated from a family meeting and any information that supports that decision.

5. For re-assessment of continued need in a QRTP, please describe what interventions or supports are needed to the child or youth to a family-based setting.

I certify that a **Family Team Decision Meeting** was conducted on _____ (date of FTDM), which included the child's family and permanency team, and that I have made the following determination: (Choose one)

☐ The child's current clinical needs cannot be met in a family member's, a resource (foster) family's home, or another non-family based placement setting because:

1. The needs of the child cannot be met with family members or through placement in a foster family home because the family is unable or unwilling to control the child's behavior and placement in a foster family home is contrary to the welfare of the child and public safety, AND
2. A QRTP is the setting which will provide the most effective and appropriate level of care for the child in the least restrictive environment and will be consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child. (Section 475A(c)(1) of the Act).

☐ The child's needs do not warrant a QRTP setting because they can be met within a family-based setting

SIGNATURE OF Qualified Individual:

PRINTED NAME:

TITLE:

PHONE #: