

EXHIBIT D

COUNTY OF LOS ANGELES
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
Safe Children and Strong Families (SCSF)

STATEMENT OF WORK
(RFP # 11-053A)

ADOPTION PROMOTION AND SUPPORT SERVICES (APSS)

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STATEMENT OF WORK

Safe Children and Strong Families (SCSF)
ADOPTION PROMOTION and SUPPORT SERVICES (APSS)

SECTION A - PREAMBLE

The County of Los Angeles seeks to collaborate with its community partners to enhance the capacity of the health and human services system to improve the lives of children and families. These efforts require, as a fundamental expectation, that the County's contracting partners share the County and community's commitment to provide health and human services that support achievement of the County's Strategic Plan Mission, Values, Goals and Performance Outcomes.

The County of Los Angeles' Vision is to improve the quality of life in the COUNTY by providing responsive, efficient, and high quality public services that promote the self-sufficiency, well-being and prosperity of individuals, families, business and communities. This philosophy of teamwork and collaboration is anchored in the County's shared values of 1) Accountability; 2) A Can-Do Attitude; 3) Compassion; 4) Customer Orientation; 5) Integrity; 6) Leadership; 7) Professionalism; 8) Respect for Diversity; and 9) Responsiveness.

These shared values are encompassed in the County's Strategic Plan's five Goals: 1) Operational Effectiveness; 2) Children, Family and Adult Well-Being; 3) community and Municipal Services; 4) Health and Mental Health; and 5) Public Safety. Improving the well-being of children and families requires coordination, collaboration and integration of services across functional and jurisdictional boundaries, by and between County departments/agencies and community and contracting partners.

SECTION B – PROJECT FOUNDATION

1.0 PURPOSE

The Adoption Promotion and Support Services program is funded by the Promoting Safe and Stable Families (PSSF) program and is part of a continuum of care consistent with the DCFS Shared Core Practice Model, Exhibit D-9, which ensures that the physical, emotional, social and educational needs of children are met in a safe and nurturing environment. DCFS and PROBATION partner with community-based contractors to provide adoption-focused specialized services when adoption is in the best interest of the child.

1.1 The objectives and delivery of the Adoption Promotion and Support Services program shall be designed to encourage, expedite and maintain children in care through Los Angeles County DCFS in safe, loving adoptive homes. Services consist of therapy, mentors, support groups,

case management and linkages to services not directly provided by the contractor's program.

2.0 COUNTY PROGRAM MANAGEMENT

The COUNTY shall provide a Program Manager to coordinate the delivery of the services of this Contract with the CONTRACTOR's Program Manager (Con-PM).

- 2.1 The CPM (CPM) or designated alternate will have full authority to monitor CONTRACTOR's performance in the day-to-day operation of this Contract.
- 2.2 The CPM will provide direction to CONTRACTOR in areas relating to DCFS and Probation policy, information and procedural requirements.
- 2.3 The CPM, responsible for daily management of Contract operation and overseeing monitoring activities, is identified in Attachment K.
- 2.4 The CPM is not authorized to make any changes in the terms and conditions of this Contract and is not authorized to obligate the COUNTY in any way whatsoever beyond the terms of this Contract.
- 2.5 CONTRACTOR shall attend a mandatory orientation that shall be provided by COUNTY within thirty (30) days of the Contract Start Date. CONTRACTOR shall be notified at least two weeks in advance of the date, time, and location of the orientation.

3.0 CONTRACTOR'S GENERAL RESPONSIBILITIES

- 3.1 As required in Part II, Section 1.0, Contractor's Administration, CONTRACTOR shall designate a Program Manager responsible for daily management of Contract operation and overseeing the work to be performed by CONTRACTOR as defined in this Statement of Work. The Con-PM is identified in Attachment J.
- 3.2 The Con-PM shall be responsible for CONTRACTOR's day-to-day activities as related to this Contract, and shall coordinate with the CPM on a regular basis.
- 3.3 CONTRACTOR agrees that any work performed outside the scope of this SOW shall be deemed a gratuitous act on the part of CONTRACTOR and, therefore, CONTRACTOR shall have no claim against COUNTY.
- 3.4 CONTRACTOR shall not schedule or conduct any meetings or Negotiations under this Contract on behalf of the COUNTY or DCFS or Probation.
- 3.5 CONTRACTOR shall request approval from the CPM in writing of any change(s) in CONTRACTOR's key personnel at least three (3) business

days before proposed change(s), including name and qualifications of new personnel. CONTRACTOR shall ensure that no interruption of services occur as a result of the change in personnel.

- 3.6 CONTRACTOR shall hold weekly supervision reviews with all professional staff, paraprofessional staff, interns, and all other staff that provide program services under this contract, with the exception of mentors and volunteers who may be supervised on a monthly basis. Copies of sign in logs, agendas and any other supervision materials shall be made available to the CPM upon request. Supervision reviews may be held individually or as a group.
- 3.7 CONTRACTOR shall maintain documentation in the personnel files of all Professional and Paraprofessional Staff, Mentors interns, and volunteers of its staff:
 - 3.7.1 All training hours and topics;
 - 3.7.2 Copies of resumes, degrees and professional licenses; and
 - 3.7.3 Criminal clearances and background checks.

4.0 TARGET POPULATIONS

Adoption Promotion and Support Services targets the following demographic:

- 4.1 Children (under 18 years) with an alternative permanent plan of adoption for whom adoption recruitment efforts are underway.
- 4.2 Children in a planned permanent living arrangement that could benefit from a more permanent plan of adoption.
- 4.3 Children who are hesitant about being adopted.
- 4.4 Families involved in the DCFS/Probation adoption process, including pre-adoption activities, participation in partnering in Safety and Permanence – Model Approach for Partnership in Parenting (PS-MAPP) and the adoption home study.
- 4.5 Children and families in need of support and services before, and after adoption finalization.
- 4.6 Families in need of support services due to risk of adoption disruption after adoption finalization.
- 4.7 Families adopting a sibling group.

5.0 STAFF REQUIREMENTS, TRAINING, and RETENTION

5.1 Staff Requirements

CONTRACTOR shall ensure that criminal clearances with subsequent arrest notification and background checks have been completed for all CONTRACTOR's staff and volunteers as well as all Subcontractors' staff, prior to beginning and continuing work under any resulting Contract (see section 8.17, Criminal Clearances, of Sample Contract). The cost of such criminal clearances and background checks is the responsibility of the CONTRACTOR and Subcontractors.

- 5.1.1 CONTRACTOR's personnel, as well as all Subcontractor staff who are performing services under this Contract, shall be able to read, write, speak, and understand English in order to conduct business with COUNTY.
- 5.1.2 CONTRACTOR shall ensure there is a sufficient number of bilingual staff to meet the language needs of the community served. County shall submit a corrective action plan if provider does not have a bilingual case worker for longer than four months.
- 5.1.3 CONTRACTOR shall ensure all professional and paraprofessional, mentors and staff and volunteers providing program services are able to provide services in a manner that effectively responds to differences in cultural beliefs, behaviors and learning, and communication styles within the community CONTRACTOR proposes to provide services.
- 5.1.4 CONTRACTOR must maintain copies of current driver's licenses, including current copies of proof of auto insurance for staff providing transportation on an as-needed basis to clients, for as long as staff is employed by CONTRACTOR.
- 5.1.5 CONTRACTOR must maintain copies of driver's Department of Motor Vehicles (DMV) printouts for all CONTRACTOR's staff providing transportation on an as-needed basis to clients under this Contract, for as long as staff is employed by CONTRACTOR. Reports shall be available to the CPM on request.
- 5.1.6 CONTRACTOR shall be responsible for securing and maintaining staff who meet the minimum qualifications below and who possess sufficient experience and expertise required to provide services required in this SOW. CONTRACTOR shall obtain written verification for staff with foreign degrees that the degrees are recognized as meeting established standards and requirements of an accrediting agency authorized by the U.S. Secretary of Education.

- 5.1.7 Professional Staff: Professional staff shall have, at minimum, a Bachelor's Degree in Social work, Psychology, Marriage and Family Counseling or a closely related field.
- 5.1.8 Paraprofessional Staff: There are no minimum degree requirements for paraprofessional staff, however, CONTRACTOR shall ensure that all paraprofessional staff possess the expertise and experience necessary to provide direct client services as required in this SOW.
- 5.1.9 Program Manager: The Program Manager shall have, at minimum, a Bachelor's degree from an accredited school in a social science or a closely related field and two years full-time management experience in a social service agency.
- 5.1.10 Clinical Director: The Clinical Director shall be one of the following: (1) a Licensed Clinical Social Worker (LCSW) with a current license from the California Board of Behavioral Sciences; (2) a Licensed Marriage and Family Therapist (LMFT) with a current license from the California Board of Behavioral Sciences; or (3) a licensed Psychologist with a current license from the California Board of Psychology; or an equivalent license recognized by the California Board of Behavioral Science Examiners.
- 5.1.11 APSS Professional Therapist Staff who provides therapy to families and children must possess, at minimum, a Master's Degree in social work, psychology, marriage and family counseling or a closely related field. Non-licensed Professional Therapy Staff must be registered with the Board of Behavioral Sciences gaining hours for licensure as an LMFT/LCSW or equivalent license. Professional Therapist Staff shall have a minimum of two (2) years of adoption experience, including, but not limited to, an awareness of the developmental process of adoption and training in adoption therapy strategies and techniques including the Seven Core Issues of Adoption.
- 5.1.12 APSS Supervising Therapist shall be currently licensed as a Licensed Clinical Social Worker (LCSW), a Licensed Marriage and Family Therapist (LMFT), or Licensed Clinical Psychologist, or an equivalent license recognized by the California Board of Behavioral Science Examiners with a minimum of five (5) years adoption experience.

5.2 Staff Training

CONTRACTOR shall train all professional and paraprofessional staff, and interns providing program services within sixty (60) business days from their start date. CONTRACTOR shall train all mentors, volunteers and part-time staff providing program services within ninety (90) business days from

their start date. This training shall consist of a minimum of forty (40) hours. This training to include, but not be limited to: (1) identifying child safety issues; (2) instructing staff and volunteers in mandated reporting requirements; (3) working with families affected by abuse and neglect; (4) learning methods of identifying and building family strengths; (5) the Seven Core Issues of Adoption (6) the Strengthening Families: Protective Factors Framework (7) the DCFS Shared Core Practice Model; (8) helping parents build on their own skills and confidence; (9) promoting positive parent-child and family interaction; (10) learning record keeping procedures and accurate completion of the Family Functioning Assessment Tool (FAF) if in use by APSS; (11) linking families to community services and resources and (12) issues of cultural competency, disparity and disproportionality.

5.2.1 CONTRACTOR shall ensure all professionals, Paraprofessional, interns staff, volunteers, and Subcontractors' staff providing Program services receives regular, ongoing in-service training and supervision. CONTRACTOR's staff shall receive a minimum of eight (8) hours of training each quarter of the Contract term. APSS professionals who have worked in an adoption agency for two years or more would qualify for a reduction to 16 hours of training per fiscal year. CONTRACTOR shall hold weekly supervision reviews with all professional staff, paraprofessional staff, interns, and volunteers. CONTRACTOR shall hold monthly supervision reviews with all mentors and volunteers.

5.3 Staff Record Retention

CONTRACTOR shall maintain documentation in the personnel files of all Professional, and Paraprofessional Staff, mentors, interns, and volunteers of its staff: (1) all training hours and topics; (2) copies of resumes, degrees, and professional licenses; and (3) current criminal clearances and background checks for five years after the employee or volunteer has ceased employment with the CONTRACTOR.

5.4 Staff Reports

5.4.1 CONTRACTOR shall provide the CPM, at the beginning of each Contract term and within 15 days of any staff change(s), a roster of all staff that includes: (1) name and positions; (2) work schedule; and (3) fax and telephone numbers.

SECTION C – SERVICE DESCRIPTION

6.0 SCOPE OF WORK

Adoption Promotion and Support Services (APSS) provides services consistent with the DCFS Shared Core Practice Model, Exhibit D-9, to children and families either currently or previously involved with DCFS and Probation who are in various stages of the adoption process. Adoption is promoted when it is in the

best interest of the child. DCFS contracts with Community-based agencies located within the eight Service Planning Areas (SPA) of Los Angeles County to provide coordinated services. These community based agencies must have adoption expertise and be trained to focus on adoption-related issues.

Services to be rendered under APSS are: APSS Referrals; Case Management Services; Adoption-Focused Therapy (individual, family, and/or group therapy); APSS Mentor Program; Support Groups (for children and/or adults); and referrals for Linkage Services that can include, but is not limited to: childcare, health care, mental health, physical and developmental services, Regional Center Services, educational, special education, substitute adult role model, parenting and/or other education programs, income support, transportation services and concrete supports.

Based on the history of APSS referrals DCFS expects an average of approximately 51 yearly referrals for SPA 1; 91 yearly referrals for SPA 2; 92 yearly referrals for SPA 3; 18 yearly referrals for SPA 4; 30 yearly referrals for SPA 5; 73 yearly referrals for SPA 6; 70 yearly referrals for SPA 7; and 80 yearly referrals for SPA 8.

The Five Protective Factors

The five protective factors listed below are the foundation of the Strengthening Families approach. Extensive research support the common-sense notion that when these Protective Factors are present and robust in a family, the likelihood of child abuse and neglect diminishes.

- Parental resilience: Parents who are emotionally healthy are able to maintain a positive attitude, creatively solve problems and effectively rise to the challenges that emerge in every family's life.
- Social connections: Everyone benefits from a strong network of extended family, friends, neighbors and others who provide healthy relationships, support and problem solving.
- Knowledge of parenting and child development: Parents who understand the usual course of child development are more likely to be able to nurture their children's healthy development and less likely to be abusive or harmful to their children.
- Concrete support in times of need: Families need to have basic needs (shelter, food, clothing, health care) met to ensure a child's healthy development.
- Social and Emotional Competence of Children: A child's emerging ability to interact positively with others, self-regulate their behavior and effectively communicate their feelings has a positive impact on their relationships with their family, other adults and peers.

6.1 Initial Transfer of Records

6.1.1 At the start of a new contract, CONTRACTOR shall accept all transitioned cases from the prior CONTRACTORS or non-renewed CONTRACTORS. The new CONTRACTOR shall submit a plan of coverage to the CPM for the transitioned cases within 30 days of the start of the new contract or within 30 days of receipt of transitioned cases from the non-renewed CONTRACTOR. The plan of coverage shall include (1) telephonic contact with the family within three weeks of the 30 day transitional period (2) a face to face contact with the family within five business days from the telephonic contact (3) an initial case plan for the family by the close of the 30 day transitional period.

6.2 APSS Services

CONTRACTOR shall take into consideration the family's protective factor needs, and the Seven Core Issues of Adoption. APSS services shall facilitate the development and strengthening of parental protective factors; consistent with the Strengthening Families: Protective Factors Framework and addressing the Seven Core Issues of Adoption.

6.3 Adoption Promotion and Support Services (APSS) Referrals

The CONTRACTOR shall accept referrals on the Adoption Promotion and Support Services Referral (Exhibit D-8) from Adoption Promotion and Support Services staff, and other DCFS contracted APSS providers. The referral process for APSS is detailed in Exhibit D-4.

6.3.1 CONTRACTOR shall accept the referral from the CPM or designee regardless of where the family resides within Los Angeles County. Efforts will be made by the CPM or designee to assign referrals based upon the home address however other considerations may take precedence. CPM, or designee, in collaboration with CONTRACTOR, shall determine the appropriateness of referrals, if the CONTRACTOR, after assessing the child and/or family, regards them as inappropriate for APSS services. The COUNTY reserves the right to make the final decision.

6.3.2 CONTRACTOR's receipt of the DCFS and Probation referral from the APSS CPM or designee or from another APSS provider shall constitute an official referral of the child and/or family to the CONTRACTOR. Proof of referral receipt is by fax stamp or by date /time of email containing scanned referral.

6.3.3 CONTRACTOR must receive written approval from CPM or designee prior to establishing a wait list. Once approved, continuance of a wait list beyond one month is at the discretion of the CPM or designee. In the event a wait list is approved, CPM will

consider re-assigning the wait-listed referral(s) to a provider outside the service area. The extension of priority to a family is at the discretion of the CPM.

6.3.3.1 Clients with critical needs wait-listed in excess of ten business days shall be referred to and linked with other COUNTY APSS contractors who do not have a wait list.

6.3.3.2 CONTRACTOR shall make weekly telephone contact with families on the wait list and consult with APSS CPM or designee on an as-needed basis if the family requests immediate services or if the family's situation destabilizes.

6.3.3.3 Within 30 days of a family's placement on a wait list, CONTRACTOR shall either provide services or refer the family to another APSS provider that does not have a wait list. Such referral shall not be made prior to approvals by the CPM, the CSW, the PAS Worker, and the family; and receipt of the CPM's confirming e-mail.

6.3.4 CONTRACTOR shall make contact with the family, case-carrying CSW/Probation Officer or Post Adoption Services (PAS) CSW within two (2) business days of the effective date listed on the referral form. CONTRACTOR shall have initial face to face contact with the child and/or family within five (5) business days of the effective date listed on the referral form.

6.3.5 CONTRACTOR shall immediately notify both the CPM or designee and case carrying CSW or PAS CSW when CONTRACTOR is unable to make contact with the family within two (2) business days of the effective date listed on the referral form, or have initial face to face contact within five (5) business days.

6.3.6 CONTRACTOR shall notify via email, both the CPM or designee and the case carrying CSW/Probation Officer or PAS CSW within five (5) business days of the refusal of services by a child and/or family referred by DCFS or Probation.

6.3.7 If CONTRACTOR is unable to make contact with the family within five (5) business days of the effective date on the referral form, CONTRACTOR shall contact the CPM or designee to discuss if the referral should be closed or additional attempts should be made. COUNTY reserves the right to decide the number of additional attempts needed prior to closing the referral.

6.3.8 If the individual APSS CONTRACTOR has a protocol which requires speaking with the CSW/Probation Officer prior to speaking with the child or family before the initial face to face with the child or

family, the CONTRACTOR shall notify the CPM or designee when the CONTRACTOR is unable to contact the CSW/Probation Officer within 2 business days of the effective date on the referral form. Initial contact with child/family shall occur within 5 business days of the effective date of the referral.

6.3.9 APSS services of case management, support groups, mentoring and therapy shall be made available in the location which best serves the needs of the child and/or family, including within a Probation Camp or a Group Home. The APSS Contractor will meet with and/or contact the DPO of Record prior to visiting with the Probation child, and the DPO of Record will facilitate entry into the Probation Camp or Group Home and communication with the contact person at the facility.

6.3.10 At least one of CONTRACTOR's assigned APSS professional staff (case manager, therapist, mentor, support group staff) shall have face to face meetings with the child and/or family at a frequency that is appropriate to the needs of the child and/or family and situation, but at a minimum of once a month to: (1) continue to provide APSS services according to the ISP (2) review and update the ISP due to changes within the family and changes needed in the supports and services provided; and (3) prepare for transition.

6.3.11 For Probation youth, the CONTRACTOR is required to attend at a minimum of one MDT/TDM Meeting with the Group Home, Therapist, DPO/CSW and Permanency Officer to discuss the case in it's entirety. CONTRACTOR shall provide monthly, or as needed, case updates via email and face-to-face with CSW and/or DPO regarding child and Family's progress and any changes in services or child and/or Family's situation. CONTRACTOR's case carrying staff shall be available for telephone consultation with CSW and/or DPO as needed regarding case concerns.

6.4 Case Management Services

CONTRACTOR shall obtain the information necessary to determine which CONTRACTOR or Linkages services are needed to address the family's protective factor needs, and the 7 Core Issues of Adoption. This information shall also include: (1) the Adoption Promotion & Support Services Intake/Exit Form (Exhibit D-7) identifying information form with all pertinent demographic information; (2) documentation of the consent of caretaker for admission, treatment, evaluation, aftercare or research.

6.4.1 CONTRACTOR shall develop in partnership with the family and consistent with the DCFS Shared Core Practice Model, a written initial service plan consistent with the Strengthening Families: Protective Factors Framework including: (1) documentation of client strengths and needs; (2) measurable goals and objectives related

specifically to client strengths and needs; (3) method of achieving goals (i.e., what services will be provided, how will services be provided), and who will provide the services); and (4) a plan of activities to be accomplished with the client.

6.4.1.1 CONTRACTOR will engage family in the case planning process consistent with DCFS Shared Core Practice Model, Exhibit D-9, and actively participate as a Child and Family Team member.

6.4.2 CONTRACTOR shall complete the initial service plan within 30 days of the effective date on the referral form. All involved parties shall sign and date the ISP. Changes to the plan shall be agreed upon by the client and the provider.

6.4.3 Consistent with the DCFS Shared Core Practice Model, every 90 days CONTRACTOR shall review the family's progress toward achieving their service plan and completing the APSS program. Documentation of client progress shall include and document the following: (1) central issues encountered; (2) existing protective factors (3) client response; (4) skills learned and applied by client; (5) progress towards goals; (6) barriers to progress; (7) contacts with or from other agencies; (8) service provider's impressions; (9) reports from other involved professionals. The progress notation shall include date, time and duration of contact, a list of participants, type of service and signature of individual completing the summary.

6.4.4 CONTRACTOR shall establish and maintain a network of COUNTY contracted and non-contracted community partnerships comprised of service providers and resources.

6.4.4.1 CONTRACTOR shall ensure that the service providers and resources are located in the community the CONTRACTOR proposes to serve.

6.4.4.2 CONTRACTOR shall provide follow-up services to ensure that all families referred to a linkage service receives the necessary service and/or resource within five (5) business days of the referral date.

6.4.4.3 CONTRACTOR shall document all linkage referrals on Exhibit D-3, Adoption Promotion and Support Services Monthly Summary Report and Exhibit D-4, Adoption Promotion and Support Services Referral Process.

6.4.4.4 CONTRACTOR shall ensure that families are referred and linked to the agency best able to accommodate the family's needs. All services and attempts to provide services shall be documented in the case record. The COUNTY reserves the right to approve the forms used in this documentation.

6.4.4.5 CONTRACTOR shall ensure that recommended linkage services address the identified needs consistent with the DCFS Shared Core Practice Model, Exhibit D-9.

6.5 Therapy

CONTRACTOR or Sub-contractor shall provide Individual, Family and Group Therapy (reimbursed through Medi-Cal) according to the needs of the child with the ultimate goal of the child being adopted or to remain safely in adoptive home. If therapy is not provided weekly, the rationale shall be documented in the case record and discussed with the case carrying case carrying CSW/Probation Officer, Post Adoptions Service (PAS) CSW or CPM or designee.

CONTRACTOR, or Sub-contractor of mental health services, shall be a Medi-Cal provider and provide Medi-Cal eligible services to clients required to receive therapy services under APSS. Adults who do not qualify for Medi-Cal and/or children who are not eligible to receive therapy because they do not meet the Medi-Cal qualifications; or children who need more than the individual therapy modality, can also be addressed using other APSS services, such as mentoring and support groups.

6.5.1 Individual Therapy

Therapy shall be provided at the maximum amount reimbursable by Medi-Cal.

6.5.2 Family Therapy

CONTRACTOR shall provide family therapy to those families who are either matched with a child or have a child placed in their home.

6.5.2.1 Family and group therapy shall not supplant individual therapy, but shall be a supplemental service unless clinically indicated. The clinical rationale must be documented in the case record and discussed with the case carrying CSW/Probation Officer, Post Adoptions Service (PAS) CSW, or CPM or designee.

6.5.2.2 CONTRACTOR shall address clinical issues in individual, group and family therapy that includes but is not limited to the 7 Core Issues of Adoption.

6.5.2.3 CONTRACTOR shall assist child(ren) hesitant about adoption in exploring and resolving therapeutic issues including but not limited to past losses rejections and disappointments so that these issues do not impact their potential for a permanent adoptive home.

6.5.3 Group Therapy

CONTRACTOR shall provide group therapy to referred children when clinically indicated.

6.5.3.1 CONTRACTOR shall offer group therapy sessions at a minimum every other week, but it is preferable that they be offered on a weekly basis.

6.5.3.2 CONTRACTOR shall offer an alternate day and alternate group when group membership reaches eight (8) children.

6.5.3.3 CONTRACTOR shall have therapists available to mentors for consultation. If a child or family is currently receiving therapy, the therapist should be consulted whenever possible before referral to a support group or mentor program.

6.6 APSS Mentor Program

CONTRACTOR shall provide mentors who may be adoptive parents, including kin and foster/adoptive parents, adoptees who are now adults, and former foster children who resided in foster care for at least three years. Support can include providing insight into the adoption process, sharing personal experiences, referral by the assigned case manager to community resources, and assistance throughout the adoption process. Mentors shall reflect the cultural, ethnic and demographic population served by the CONTRACTOR.

6.6.1 CONTRACTOR shall recruit mentors and provide ongoing training for mentors;

6.6.2 CONTRACTOR shall provide access to the professional therapists for consultation;

6.6.3 CONTRACTOR shall publicize the APSS Mentor Program in the community the CONTRACTOR serves.

- 6.6.4 CONTRACTOR shall dedicate a telephone line for the APSS Mentor Program;
- 6.6.5 CONTRACTOR shall convene monthly mentor meetings, commencing the second month of the contract term, to provide support, to create opportunities for training and to provide an opportunity to learn from the experiences of the other mentors.
- 6.6.6 In fulfilling the duties prescribed under the APSS Mentor Program, Mentors shall:
 - 6.6.6.1 Mentor parents and children involved at any point with the COUNTY adoption process, or who are a prior finalized adoption through the COUNTY.
 - 6.6.6.2 Mentor children with an alternate permanent plan of adoption for whom recruitment efforts are underway, and children in a planned permanent living arrangement who could benefit from a more permanent plan of adoption;
 - 6.6.6.3 Discuss adoptions with children who may be hesitant about adoptions;
 - 6.6.6.4 Meet with clients at least once monthly. If mentor is unable to meet with client once monthly, mentor shall have weekly telephone contact with the client for the month without face to face contact. The month following the month without a contact meeting shall include a face to face meeting between the mentor and the client.
 - 6.6.6.5 Present a monthly promotion in the community, such as dissemination of information and presentations at community agencies, religious institutions and other organizations with whom the mentor is involved. CONTRACTOR shall inform CPM in writing at least six business days prior to the date of monthly promotion.

6.7 Support Groups

CONTRACTOR shall provide Support Groups in English. Groups shall be provided in Spanish whenever there are at least four clients who state their preference for a Spanish-speaking group. Support groups shall be provided for: (1) prospective and adoptive parents (including kin-adopt parents); (2) birthparents; and (3) children (including children who have an alternate permanent plan of adoption) to discuss concerns, issues, frustrations, experiences, and successes related to adoption as well as everyday family life and child rearing.

6.7.1 CONTRACTOR shall give priority to families with older children and sibling sets that are in the early stages of adjusting to adoptive placement or are waiting for adoption finalization.

6.8 Training Workshops

APSS CONTRACTORS shall offer on a quarterly basis every year, a minimum of one adoption-focused training workshop to community health professionals.

6.9 Quality Service Review (QSR)

CONTRACTOR shall fully cooperate with and participate in both the development and implementation of any proposed QSR. The COUNTY's Program Manager will review and have the final approval authority over the QSR component and its implementation process.

6.10 Quality Assurance Plan

Tracking and Adapting are critical components of the DCFS Shared Core Practice Model, Exhibit D-9. Consistent with the DCFS Shared Core Practice Model, the CONTRACTOR shall establish and maintain a Quality Assurance Plan (QAP) to ensure compliance with the requirements of the contract.

6.10.1 CONTRACTOR shall submit a draft of its QAP for evaluation to demonstrate how all of the requirements of the Contract will be met. A finalized copy of the plan shall be provided to the CPM within thirty (30) days of the Contract start date and as changes occur.

6.10.1.1 The QAP shall include a description of how the CONTRACTOR's service delivery model components align with the Strengthening Families: Protective Factors Framework.

6.10.1.2 The QAP shall include a description of how the Strengthening Families: Protective Factors Framework will be measured.

6.10.1.3 The QAP shall include a description of how the CONTRACTOR's service delivery model will align with the DCFS Shared Core Practice Model, which includes engaging, teaming, assessment and understanding, planning and intervening, and tracking and adapting.

6.10.2 The original QAP and any revisions thereto shall include, but not be limited to, the following:

6.10.2.1 Methods used to ensure that the quality of service performed fully meets the performance requirements set forth in the Statement of Work. CONTRACTOR shall include methods for identifying and preventing deficiencies in the quality of service performed before the level of performance becomes unacceptable.

6.10.2.2 Methods for insuring uninterrupted service to COUNTY in the event of a strike by CONTRACTOR's employees or any other potential disruption in service.

6.10.2.3 A record of all inspections conducted by the CONTRACTOR, any corrective action taken, the time a problem was first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action, shall be provided to the COUNTY upon request.

6.10.3 The QAP will be reviewed annually by CONTRACTOR and COUNTY CPM and revised, if needed.

6.11 Quality Assurance Monitoring

The CPM, or designee, will monitor and evaluate CONTRACTOR's performance under this contract. All monitoring will be conducted in accordance with Part II, Standard Terms and Conditions, Section 24.0 - COUNTY's Quality Assurance Plan, of the Contract.

6.11.1 CONTRACTOR will be subject to a program review by the COUNTY, at a minimum of once per year, for the period of the contract.

6.11.2 If CONTRACTOR performance requirements are not met, the COUNTY CPM may call CONTRACTOR, and/or send CONTRACTOR a User Complaint Report (UCR). CONTRACTOR shall respond to a call within one hour and respond to a UCR within 24 hours of receipt. All performance requirement issues will be reported to the CPM.

6.11.2.1 CONTRACTOR shall submit a Corrective Action Plan (CAP) for any areas found to be deficient as a result of the technical review, including billing deficiencies, within forty-five (45) calendar days of the receipt of the Technical Review Findings.

7.0 TRANSFER OF RECORDS

Prior to contract termination or non-renewal of contract, contractors shall cooperate in transitioning cases which are not ready to close to new contractors,

including providing all original case files and electronic records. The transitional plan shall be made in consultation with the County Program Manager at least one month in advance of the contract termination or as soon as possible in the event of non-renewal.

8.0 PERFORMANCE OUTCOME SUMMARY

CONTRACTOR shall adhere to the measures established in Sections D of this SOW.

Safe Children and Strong Families (SCSF)
SECTION D – Performance Outcome Summary
ADOPTION PROMOTION and SUPPORT SERVICES

SERVICE CATEGORY TARGET GROUP			
Children and families either currently or previously involved with Los Angeles County DCFS and Probation who are in various stages of the adoption process. Hesitant children who could benefit from a plan of adoption.			
DCFS OUTCOME	OUTCOME PERFORMANCE INDICATOR	PERFORMANCE TARGET	MONITORING METHODS
<p>Goal: PERMANENCY</p> <p><i>Reduction in the number of children remaining in care</i></p> <p><i>Increase in the number of children in permanent adoptive homes</i></p>	<ol style="list-style-type: none"> 1. CONTRACTOR shall document efforts to contact family within two business days of the effective date of the referral. 2. CONTRACTOR shall document efforts to meet face-to-face with family to provide services within five business days of the effective date of the referral. 3. CONTRACTOR shall contact family within two business days and complete initial home visit within five business days of the effective date of the referral. 4. CONTRACTOR shall complete an individualized service plan that is inclusive of the strengths and needs assessment and protective factors framework with signatures of all participants. 5. CONTRACTOR shall complete individualized service plan within 30 days of the effective date of the referral. 6. CONTRACTOR shall provide services to all clients as specified in their case plan. 7. CONTRACTOR shall at three month intervals, conduct ongoing reviews and documentation of the client's progress toward achieving goals as identified in case plan. 8. CONTRACTOR will offer Medi-Cal eligible mental health services as specified in the client's case plan. 9. APSS services shall facilitate the development and strengthening of parental protective factors; consistent with the DCFS Shared Core Practice Model, the Strengthening Families: Protective Factors Framework and addressing the Seven Core Issues of Adoption. 	<ol style="list-style-type: none"> 1. 100% adherence to County requirements as stated in this contract 2. 100% adherence to County requirements as stated in this contract 3. 90% adherence to County requirements as stated in this contract 4. 100% adherence to County requirements as stated in this contract 5. 95% adherence to County requirements as stated in this contract 6. 100% adherence to County requirements as stated in this contract 7. 100% adherence to County requirements as stated in this contract 8. 100% adherence to County requirements as stated in this contract 9. 100% adherence to County requirements as stated in this contract 	<p>Web-based Data System</p> <p>Monthly and Annual Reports</p> <p>Ad Hoc Reports as Requested by CPM</p> <p>On-Site Technical Reviews by Program Monitors</p> <p>Client Satisfaction Surveys (Exhibits D-6 and D-7)</p>

	<p>10. CONTRACTOR shall complete the required face to face mentor visits on a monthly basis or have weekly telephone contacts as required by the SOW.</p> <p>11. CONTRACTOR shall dedicate a telephone line for the APSS Mentor Program.</p> <p>12. CONTRACTOR shall present a mentor's monthly promotion in the community in which they serve per the SOW.</p> <p>13. CONTRACTOR shall provide a minimum of one adoption-focused training workshop per quarter to community partners.</p> <p>14. CONTRACTOR shall submit required reports within the SOW timeframes or as requested by CPM.</p> <p>15. CONTRACTOR shall refer clients to appropriate linkage services and follow up within five business days to ensure linkage occurred</p> <p>16. CONTRACTOR shall attend Provider meetings on a monthly basis or as scheduled by the CPM</p> <p>17. CONTRACTOR program staff shall be trained on issues of cultural competency and disparity and disproportionality</p> <p>18. Of the families that have received APSS services, the percentage of dissolutions of adoptive placement or finalized adoptive home</p> <p>19. Of the families that have received and/or completed APSS services, the percentage of children who were stabilized or made progress toward the goal of a permanent adoptive home</p>	<p>10. 100% adherence to County requirements as stated in this contract</p> <p>11. 100% adherence to County requirements as stated in this contract</p> <p>12. 100% adherence to County requirements as stated in this contract</p> <p>13. 100% adherence to County requirements as stated in this contract</p> <p>14. 100% adherence to County requirements as stated in this contract</p> <p>15. 100% adherence to County requirements as stated in this contract</p> <p>16. 95% adherence to County requirements as stated in this contract</p> <p>17. 100% adherence to County requirements as stated in this contract</p> <p>18. Shall not exceed a maximum of 10%.</p> <p>19. Shall meet a minimum of 70%.</p>	
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CONTRACTOR shall cooperate with COUNTY in the collection of data related to the identification of families receiving Adoption Promotion and Support Services and establishing baseline data.

EXHIBIT D

County of Los Angeles, Department of Children and Family Services
Request for Proposals for Safe Children and Strong Families (SCSF)

LIST OF EXHIBITS for STATEMENT OF WORK - EXHIBIT D

Adoption Promotion and Support Services

Exhibit D-1	APSS Cumulative Summary Report
Exhibit D-2	APSS Monthly Summary Report
Exhibit D-3	APSS Referral Process
Exhibit D-4	Referral Flowchart
Exhibit D-5	Adolescent Customer Satisfaction Survey
Exhibit D-6	Parent Customer Satisfaction Survey
Exhibit D-7	Adoption Promotional and Support Services Intake/Exit Form
Exhibit D-8	Adoption Promotion and Support Services Referral
Exhibit D-9	DCFS Shared Core Practice Model

ADOPTION PROMOTION and SUPPORT SERVICES MONTHLY SUMMARY REPORT

Agency: _____
Report Month: _____

SPA: _____

Please attach an additional page to provide any relevant details to questions 1,2, or 3.

Check One	
Yes	No

1. Were there any administrative or staff changes during the report month?
2. Did staff participate in any training during the report month?
3. Are program services/components on target, with respect to delivery, participants or costs?
- 3a. If no, please explain reasons for not meeting targets with respect to delivery, participants or costs on an addtl pg.

Total number of Referrals for the Month?	
Total number of Individuals served from New Referrals?	

	Monthly Dollar Cost	# of Adults Served	# of Teens Served	# of Children Served	# Disabled Children	# Disabled Teens	Total
Therapy							
Individual							
Group							
Family							
Support Groups							
Mentoring							
Case Management							
Linkage							
Child Care Serv.							
Health Care Serv.							
Mental Health Serv.							
Physical and Deve							
Regional Center							
Educational Serv.							
Special Education							
Subst. Adult Role							
Parenting/Other Educa							
Income Support							
Transportation							
Concrete Supports							
Other							

*Families consist of one or more individuals (i.e. an adult, teen, or child).

ADOPTION PROMOTION AND SUPPORT SERVICES REFERRAL PROCESS

Step 1

If a child and/or family is experiencing problems, having concerns or requesting assistance in dealing with issues related to adoption, APSS may be requested by a Children's Social Worker to address them. Participation by children and families is voluntary.

Step 2

Referrals are made by a Regional, Adoptions, or Post Adoptions Children's Social Worker. They are made on behalf of a child under 18 years of age, who are or once were under Juvenile Court supervision, in need of adoption specific services. The completed referral form, found on DCFS' intranet site, LA Kids, is sent to the APSS County Program Manager (CPM).

Step 3

The referral is reviewed and once accepted, is sent from the CPM to the agency in the SPA where the child and/or family resides.

Step 4

Providers make contact with the family within two business days of receiving the referral from the CPM. Face to Face contact is made with the child and/or family within five business days of the referral assignment.

Step 5

An Initial Service Plan (ISP) is completed within 30 days of the assignment. The ISP lists measurable goals and objectives related specifically to client's strengths and needs, and identifies what services will be provided and who will provide the services. The services may include: individual, group or family therapy, mentors and support groups for children and/or adults; case management; and referrals for linkage services.

Step 6

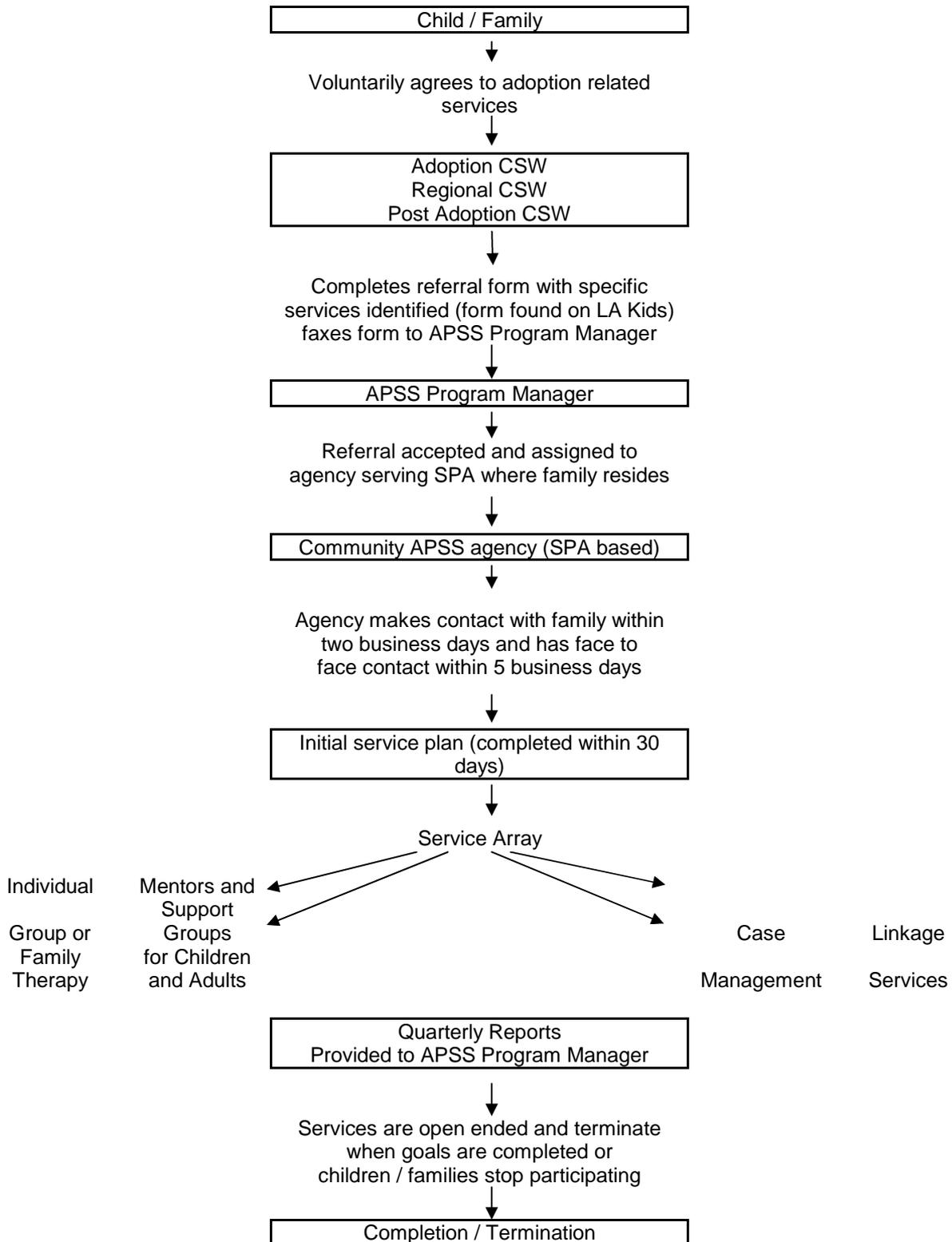
The APSS provider's quarterly reports include what services were offered to client, the appropriateness and effectiveness of the services provided, a review of the intake, and an assessment service plan and progress. Services are open-ended and terminate when family stops participating or goals are achieved.

**ADOPTION PROMOTION AND SUPPORT SERVICES
REFERRAL PROCESS**

Step 7

Upon termination, a Completion/Termination summary report is created by the APSS provider. The report includes the reason for completion/termination, the summary of services provided, the client's progress including skills taught, goals attained or not attained, progress and recommendation for future treatment, and an after care plan.

**ADOPTION PROMOTION AND SUPPORT SERVICE
REFERRAL FLOWCHART**



Adoption Promotion & Support Services Adolescent Customer Satisfaction Survey

The Department of Children and Family Services would like to know how satisfied adolescents are with the services provided by _____. Please take a few minutes to answer the following questions. The information from this survey will be kept confidential and will only be used to improve the quality of services provided to other adolescents.

Part 1. Instructions: From the list below mark ALL that apply

Ethnicity:

African American Asian/Pacific Islander Caucasian Hispanic/Latino Native American/Alaskan Native
Other

Adoption History: Matched with Family Placed in Adoptive Home Adoption Papers Signed
Adoption Finalized Adopted by Relative Adopted with Siblings

Part 1. Instructions: From the list below mark all the services that you have received.

Individual Therapy Family Therapy Group Therapy Support Group Mentoring Other _____

How many months have you been receiving services? _____

Part 2. Instructions: Please read the following attributes and rate your level of satisfaction with the services you received

	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
1. The accessibility of the agency representative.....	<input type="checkbox"/>				
2. The helpfulness/friendliness of the agency representative.....	<input type="checkbox"/>				
3. The information provided to you by the agency representative.....	<input type="checkbox"/>				
4. The responsiveness of the agency representative to any questions.....	<input type="checkbox"/>				
5. The timeliness in receiving services.....	<input type="checkbox"/>				
6. Generally, how satisfied are you with the services received.....	<input type="checkbox"/>				

Part 3. Instructions: Please read the following questions and answer them as honestly as possible.

7. Would you recommend this agency to other adolescents?.....Yes No

Why/Why Not? _____

Promoción de Adopción y Servicios de Apoyo Encuesta de Satisfacción para Clientes Adolescentes

El Departamento Servicios Familiares y de Niños quisiera saber que satisfechos están los adolescentes con los servicios proveídos por _____. Favor de tomar unos minutos para contestar las siguientes preguntas. La información de esta encuesta se mantendrá confidencial y solo será utilizada para mejorar la calidad de los servicios proveído a otros adolescentes.

Parte 1. Instrucciones: Marque *TODO* el que aplica usando la lista abajo...

Etnicidad:

- Afro-Americano
 Asiático/ Isleño Pacífico
 Caucásico
 Hispano/Latino
 Indio Americano/ Nativo de Alaska
 Otro

Historia de Adopción:

- Emparejado con una familia
 Colocado en Hogar adoptivo
 Documentos de adopción firmados
 Adopción Finalizada
 Adoptado por parientes
 Adoptado con hermanos/as

Parte 1. Instrucciones: De la lista abajo, marque todos los servicios que ha recibido...

- Terapia Individual
 Terapia Familiar
 Terapia en Grupo
 Grupo de Apoyo
 Servicios con un Mentor
 Otro

¿Por cuantos meses ha estado recibiendo servicios usted?: _____

Parte 2. Instrucciones: Favor de leer los siguientes atributos y clasifique el nivel de satisfacción con los servicios que usted recibió.

	Muy Satisfecho	Satisfecho	Neutral	Insatisfecho	muy insatisfecho
1. La accesibilidad del representante de la agencia.....	<input type="checkbox"/>				
2. La amabilidad y lo servicial que fue el representante de la agencia.....	<input type="checkbox"/>				
3. La información que le proveyó el representante de la agencia..	<input type="checkbox"/>				
4. El interés del representante de la agencia sobre sus preguntas.....	<input type="checkbox"/>				
5. La puntualidad en recibir servicios.....	<input type="checkbox"/>				
6. El general, ¿que tan satisfecho estuvo usted con los servicios que recibió?.....	<input type="checkbox"/>				

Parte 3. Instrucciones: Favor de leer las siguientes preguntas y contéstelas lo mas honesto posible.

7. ¿Recomendaría usted esta agencia a otros adolescentes?..... Si No

¿Por qué si/¿Por qué no? _____

EXHIBIT D-5

Niño
Pagina 2 de 2

8. En espacio abajo, por favor déjenos saber que podríamos hacer para mejor servirle.

9. ¿Estaría usted interesado en discutir su experiencia con un representante del Departamento de Servicios para Niños y Familias (DCFS)?..... Si No

Si le gustaría, favor de proporcionarlos la siguiente información para que el representante de DCFS se pueda comunicar con usted.

Nombre completo (primer y apellido)	Numero de teléfono	Hora mas conveniente para usted
-------------------------------------	--------------------	---------------------------------

10. ¿Algún otro comentario?

Adoption Promotion & Support Services Parent Customer Satisfaction Survey

The Department of Children and Family Services would like to know how satisfied care providers are with the services provided by _____. Please take a few minutes to answer the following questions. The information from this survey will be kept confidential and will only be used to improve the quality of services provided to other care providers.

Part 1. Instructions: From the list below mark ALL that apply

Ethnicity:

African American Asian/Pacific Islander Caucasian Hispanic/Latino Native American/Alaskan Native Other

Head of Household: Single Female Parent Single Male Parent Couple

Adoption History: Currently in PS-MAPP Homestudy Completed Matched with Child Child in Home Adoption Papers Signed Adoption Finalized Adopting Relative Adopting Siblings Previously Adopted

Part 1. Instructions: From the list below mark all the services that you have received.

Individual Therapy Family Therapy Group Therapy Support Group Mentoring Other _____

How many months have you been receiving services? _____

Part 2. Instructions: Please read the following attributes and rate your level of satisfaction with the services you received

	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
1. The accessibility of the agency representative.....	<input type="checkbox"/>				
2. The helpfulness/friendliness of the agency representative.....	<input type="checkbox"/>				
3. The information provided to you by the agency representative.....	<input type="checkbox"/>				
4. The responsiveness of the agency representative to any questions.....	<input type="checkbox"/>				
5. The timeliness in receiving services.....	<input type="checkbox"/>				
6. Generally, how satisfied are you with the services received.....	<input type="checkbox"/>				

Part 3. Instructions: Please read the following questions and answer them as honestly as possible.

7. Would you recommend this agency to others?.....Yes No

Why/Why Not? _____

Promoción de Adopción y Servicios de Apoyo Encuesta de Satisfacción

El Departamento Servicios Familiares y de Niños quisiera saber que satisfechos están los proveedores de cuidado con los servicios proveídos por _____. Favor de tomar unos minutos para contestar las siguientes preguntas. La información de esta encuesta se mantendrá confidencial y solo será utilizada para mejorar la calidad de los servicios proveído a otros adolescentes.

Parte 1. Instrucciones: Marque *TODO* el que aplica usando la lista abajo...

Etnicidad:

Afro-Americano Asiático/Isleño Pacífico Caucásico Hispano/Latino Indio Americano/Nativo de Alaska Otro

Cabeza del Hogar: Madre Soltera Padre soltero Pareja

Historia de Adopción:

Actualmente en Preparación y Selección en Grupo de Familias de Crianza y/o Adopción Estudio del Hogar Completado Emparejado con un niño Niño en el hogar Documentos de adopción firmados

Adoptado finalizada Adoptando a un familiar Adoptando hermanos/as Adoptado anteriormente

Parte 1. Instrucciones: De la lista abajo, marque todos los servicios que ha recibido...

Terapia Individual Terapia Familiar Terapia en Grupo Grupo de Apoyo Servicios con un Mentor Otro

¿Por cuantos meses ha estado recibiendo servicios usted?: _____

Parte 2. Instrucciones: Favor de leer los siguientes atributos y clasifique el nivel de satisfacción con los servicios que usted recibió.

	Muy Satisfecho	Satisfecho	Neutral	Insatisfecho	muy insatisfecho
11. La accesibilidad del representante de la agencia..... La amabilidad y lo servicial que fue el representante de la	<input type="checkbox"/>				
12. agencia.....	<input type="checkbox"/>				
13. La información que le proveyó el representante de la agencia.. El interés del representante de la agencia sobre sus	<input type="checkbox"/>				
14. preguntas.....	<input type="checkbox"/>				
15. La puntualidad en recibir servicios..... El general, ¿que tan satisfecho estuvo usted con los servicios	<input type="checkbox"/>				
16. que recibió?.....	<input type="checkbox"/>				

Parte 3. Instrucciones: Favor de leer las siguientes preguntas y contéstelas lo mas honesto posible.

17. ¿Recomendaría usted esta agencia a otros?..... Si No

¿Por qué si/¿Por qué no? _____

18. En espacio abajo, por favor déjenos saber que podríamos hacer para mejor apoyarlos como padres adoptivos.

¿Estaría usted interesado en discutir su experiencia con un representante del Departamento de Servicios para Niños y Familias (DCFS)?..... Si No

Si le gustaría, favor de proporcionarlos la siguiente información para que el representante de DCFS se pueda comunicar con usted.

Nombre completo (primer y apellido)	Numero de teléfono	Hora mas conveniente para usted
-------------------------------------	--------------------	---------------------------------

20. ¿Algún otro comentario? _____

Section D. Referred Child(ren) Information – Add more pages as needed

Child 1

State ID #:		Last, First Name:		DOB:	Gender:
Type of Placement: <input type="checkbox"/> Foster only, relative/NREFM <input type="checkbox"/> Foster only, State Licensed Home <input type="checkbox"/> Foster Only, FFA <input type="checkbox"/> Prospective Adoptive, State Licensed Home <input type="checkbox"/> Prospective Adoptive Family, FFA <input type="checkbox"/> Relative/NREFM <input type="checkbox"/> Finalized Adoptive Home <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Group Home <input type="checkbox"/> Residential Treatment Facility					
Address (if different from Adult Information):					
Phone # (if different from Adult Information):					
Email address (if applicable):					
Language (list all, starting with primary):					
Ethnicity:		<input type="checkbox"/> White, non-Hispanic <input type="checkbox"/> African American/Black <input type="checkbox"/> Native American		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian/Pacific-Islander <input type="checkbox"/> Other _____	
Sibling Information:		Does the child have birth siblings? <input type="checkbox"/> Yes <input type="checkbox"/> No Is child placed with siblings? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, is sibling: <input type="checkbox"/> Under DCFS supervision <input type="checkbox"/> adopted <input type="checkbox"/> visiting <input type="checkbox"/> Unknown			
Education Information:		Grade: _____	IEP on File? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving Special Education Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	If NO, would child benefit from SE? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health Information:		Medi-Cal number: _____			
		Is child in Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, name of therapist and phone number: _____	
		DSM Diagnosis: _____			
		Psychotropic Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, name and dosage of medication: _____			

Child 2

State ID #:		Last, First Name:		DOB:	Gender:
Type of Placement: <input type="checkbox"/> Foster only, relative/NREFM <input type="checkbox"/> Foster only, State Licensed Home <input type="checkbox"/> Foster Only, FFA <input type="checkbox"/> Prospective Adoptive, State Licensed Home <input type="checkbox"/> Prospective Adoptive Family, FFA <input type="checkbox"/> Relative/NREFM <input type="checkbox"/> Finalized Adoptive Home <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Group Home <input type="checkbox"/> Residential Treatment Facility					
Address (if different from Adult Information):					
Phone # (if different from Adult Information):					
Email address (if applicable):					
Language (list all, starting with primary):					
Ethnicity:		<input type="checkbox"/> White, non-Hispanic <input type="checkbox"/> African American/Black <input type="checkbox"/> Native American		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian/Pacific-Islander <input type="checkbox"/> Other _____	
Sibling Information:		Does the child have birth siblings? <input type="checkbox"/> Yes <input type="checkbox"/> No Is child placed with siblings? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, is sibling: <input type="checkbox"/> Under DCFS supervision <input type="checkbox"/> adopted <input type="checkbox"/> visiting <input type="checkbox"/> Unknown			
Education Information:		Grade: _____	IEP on File? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving Special Education Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	If NO, would child benefit from SE? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health Information:		Medi-Cal number: _____			
		Is child in Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, name of therapist and phone number: _____	
		DSM Diagnosis: _____			
		Psychotropic Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, name and dosage of medication: _____			

Child 3

State ID #:		Last, First Name:		DOB:	Gender:
Type of Placement: <input type="checkbox"/> Foster only, relative/NREFM <input type="checkbox"/> Foster only, State Licensed Home <input type="checkbox"/> Foster Only, FFA <input type="checkbox"/> Prospective Adoptive, State Licensed Home <input type="checkbox"/> Prospective Adoptive Family, FFA <input type="checkbox"/> Relative/NREFM <input type="checkbox"/> Finalized Adoptive Home <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Group Home <input type="checkbox"/> Residential Treatment Facility					
Address (if different from Adult Information):					
Phone # (if different from Adult Information):					
Email address (if applicable):					
Language (list all, starting with primary):					
Ethnicity: <input type="checkbox"/> White, non-Hispanic <input type="checkbox"/> African American/Black <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian/Pacific-Islander <input type="checkbox"/> Other _____					
Sibling Information: Does the child have birth siblings? <input type="checkbox"/> Yes <input type="checkbox"/> No Is child placed with siblings? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, is sibling: <input type="checkbox"/> Under DCFS supervision <input type="checkbox"/> adopted <input type="checkbox"/> visiting <input type="checkbox"/> Unknown					
Education Information:		Grade: _____	IEP on File? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving Special Education Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	If NO, would child benefit from SE? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health Information:		Medi-Cal number: _____			
		Is child in Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, name of therapist and phone number: _____	
		DSM Diagnosis: _____			
		Psychotropic Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, name and dosage of medication: _____			

Child 4

State ID #:		Last, First Name:		DOB:	Gender:
Type of Placement: <input type="checkbox"/> Foster only, relative/NREFM <input type="checkbox"/> Foster only, State Licensed Home <input type="checkbox"/> Foster Only, FFA <input type="checkbox"/> Prospective Adoptive, State Licensed Home <input type="checkbox"/> Prospective Adoptive Family, FFA <input type="checkbox"/> Relative/NREFM <input type="checkbox"/> Finalized Adoptive Home <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Group Home <input type="checkbox"/> Residential Treatment Facility					
Address (if different from Adult Information):					
Phone # (if different from Adult Information):					
Email address (if applicable):					
Language (list all, starting with primary):					
Ethnicity: <input type="checkbox"/> White, non-Hispanic <input type="checkbox"/> African American/Black <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian/Pacific-Islander <input type="checkbox"/> Other _____					
Sibling Information: Does the child have birth siblings? <input type="checkbox"/> Yes <input type="checkbox"/> No Is child placed with siblings? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, is sibling: <input type="checkbox"/> Under DCFS supervision <input type="checkbox"/> adopted <input type="checkbox"/> visiting <input type="checkbox"/> Unknown					
Education Information:		Grade: _____	IEP on File? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving Special Education Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	If NO, would child benefit from SE? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health Information:		Medi-Cal number: _____			
		Is child in Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, name of therapist and phone number: _____	
		DSM Diagnosis: _____			
		Psychotropic Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, name and dosage of medication: _____			

Section E. Information on Others Living in Household

Information on Other Adults Living in Household:

* <input type="checkbox"/>	Last Name	First Name	Ethnicity	Gender	DOB	Relation***
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						

Information on Children Living in Household

* <input type="checkbox"/>	Last Name	First Name	Ethnicity	Gender	DOB	Education Level **	Relation***
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							

<p>* Check box if adult/child will be recipient of direct services</p>	<p>** Education Level Indicate level for each child</p> <p>N-Not in School I-Infant/Toddler.(0-2 years) P-Preschooler (3-5 years) E-Elementary School (Grades K-8) H-High School C-College/Vocational</p>	<p>Ethnicity Codes</p> <p>W--White, non-Hispanic B—African American/Black N—Native American H—Hispanic/Latino A—Asian/Pacific Islander O--Other</p>	<p>**Relation select code that best describes the relationship to referred child</p> <p>B-Biological Parent R-Relative S-Sibling F-Foster Sibling N-Nonrelative Extended Family O-Other</p>
---	--	--	--

Section F: Please describe the Presenting Problems/Areas of Concern As Described by Parent/Applicant/Child (Use Additional Paper As Needed)

Section G: Please Describe Goals/Outcomes as Described by Parent/Applicant/Child (Use Additional Paper As Needed)

Section H. Preliminary Assessment of Services Needed In Addition To Case Management Services as Determined by APSS Agency

<input type="checkbox"/> 01 Individual Therapy	<input type="checkbox"/> 04 Mentor for Child	<input type="checkbox"/> 07 Support Group for Parent/Applicant
<input type="checkbox"/> 02 Group Therapy	<input type="checkbox"/> 05 Mentor for Parent/Applicant	<input type="checkbox"/> 08 Linkage (Specify)
<input type="checkbox"/> 03 Family Therapy	<input type="checkbox"/> 06 Support Group for Child	

Section I. Exit/Closing Information

Date Referral Closed:	
Closing Reason	Select a reason from code below
Transfers	Did the family move to another SPA? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If YES, was the referral transferred to another APSS Agency? <input type="checkbox"/> Yes <input type="checkbox"/> No
	a) Please indicate APSS Agency that case was transferred to:
	b) Indicate the date the referral was faxed to the new Agency:
	If NO, why wasn't the referral transferred to another Agency?
*Key for Closing Reason	
1—Completed: Stabilized	12—Client non-responsive prior to signed ISP
2—Completed: Stabilized and Finalized	13—Transferred APSS Providers prior to signed ISP
3—Agency's Services given-Client non-compliant	14—Client removed from home-higher level of care
4—Agency's Services given-Client moved SPA	15—Client removed from home-placement disruption/dissolution
5—Agency's Services given-Client moved SPA to permanent placement	16—AWOL
6—Agency's Services given-client moved to higher level of care	17—Legal Guardianship
7—Agency's Services given-client in need of more intensive services	18—Long-term foster care
8—CSW/ASW non-responsive	19—Reunification
9—Referral not appropriate	20—Death
10—Referral not appropriate and other services in place	21—Court Order
11—Client Declined prior to signed ISP	22—Other (specify)

Summary of Actual Services In Addition To Case Management Provided to Client

<input type="checkbox"/> 01 Individual Therapy	<input type="checkbox"/> 04 Mentor for Child	<input type="checkbox"/> 07 Support Group for Parent/Appl
<input type="checkbox"/> 02 Group Therapy	<input type="checkbox"/> 05 Mentor for Parent/Applicant	<input type="checkbox"/> 08 Linkage (Specify)
<input type="checkbox"/> 03 Family Therapy	<input type="checkbox"/> 06 Support Group for Child	

Additional Comments if Needed:

ADOPTION PROMOTION & SUPPORT SERVICES REFERRAL

Fax No. (213) 637-0040

A. CHILD INFORMATION

State ID	Name (Last, First, M.I.)	DOB	Phone:	Gender	Ethnicity	Status
1.						
Address	Status Date *:					
2.						
Address	Status Date *:					
3.						
Address	Status Date *:					
4.						
Address	Status Date *:					
5.						
Address	Status Date *:					
6.						
Address	Status Date *:					

*** CHILD(REN) ARE IN THE FOLLOWING ADOPTION/PERMANENCY STATUS** (Provide Number in Status Column above)

1—Hesitant about Adoption	4—Child Placed in Home that Intends on Adopting	<u>Indicate date of placement</u>
2—Adoptive Home needed	5—Child in Home of Legal Guardian	<u>Indicate date of guardianship</u>
3—Matched: Pre-Placement	6—Child in Home, Adoption Papers Signed	<u>Indicate date of signing</u>
	7—Child in Home; Adoption Finalized	<u>Indicate date finalized</u>

B. ADULT INFO	1	2	3
Name			
Address			
DOB			
Relationship to child			
Language			
Ethnicity			
Phone			
Adult Status			
DCFS Adoption #			

ADULT(S) ARE IN THE FOLLOWING ADOPTION/PERMANENCY STATUS

1—Foster Parents Only	6—Adoption Home Study in Progress: Child in home
2—Attending PS-MAPP	7— Adoption HS Complete. Child in home
3—Post PS-MAPP. Adoption Home Study (HS) in progress	8—Legal guardians
4—Adoption HS Complete: No child in home	9—Adopt Papers signed <u>Indicate date of signing</u>
5—Family Matched: Child Identified	10—Child in Home. Adoption Finalized <u>Indicate date finalized</u>

EXHIBIT D-8

ADOPTION PROMOTION & SUPPORT SERVICES REFERRAL

Fax No. (213) 637-0040

C. ADDITIONAL CHILDREN / ADULTS IN THE HOME

Name: Last	Name: First	DOB	Relationship to the Child	Ethnicity	Gender:
1.					
2.					
3.					
4.					
5.					
6.					

EXHIBIT D-8

ADOPTION PROMOTION & SUPPORT SERVICES REFERRAL

Fax No. (213) 637-0040

D. DCFS STAFF INFORMATION

REFERRING CSW			
CSW Name: Last	First	CWS File No and Email Address:	
CSW Phone No:	CSW Fax No:	Region	Office
SCSW Name: Last	First	SCSW Telephone NO.:	

ER GENERIC (FM/FR/PP)CSW ADOPTION CSW Post Adoption CSW APSS AGENCY

OTHER DCFS STAFF ASSIGNED TO CASE

OTHER DCFS STAFF ASSIGNED TO CASE			
CSW Name: Last	First	CWS File No and Email Address:	
CSW Phone No:	CSW Fax No:	Region	Office
SCSW Name: Last	First	SCSW Telephone NO.:	

ER GENERIC (FM/FR/PP)CSW ADOPTION CSW Post Adoption CSW APSS AGENCY

E. PRESENTING PROBLEMS/AREAS OF CONCERN: Please describe. (If case is transferred from one APSS agency to another, identify original presenting problems/areas of concern and any new problems/areas of concern.)

--

F. FAMILY STRENGTHS: Please describe. (If case is transferred from one agency to another, identify progress.)

--

G. REFERRING CSW OR APSS AGENCY ASSESSMENT OF SERVICES NEEDED IN ADDITION TO CASE MANAGEMENT SERVICE:

<input type="checkbox"/> 01 INDIVIDUAL THERAPY*	<input type="checkbox"/> 04 SUPPORT GROUP FOR CHILD	<input type="checkbox"/> 07 SUPPORT GROUP FOR PARENT/APPLICANT
<input type="checkbox"/> 02 GROUP THERAPY*	<input type="checkbox"/> 05 MENTOR FOR CHILD	<input type="checkbox"/> 08 LINKAGE SERVICE
<input type="checkbox"/> 03 FAMILY THERAPY*	<input type="checkbox"/> 06 MENTOR FOR PARENT/APPLICANT	

***If therapy is being requested for a court dependent child, a minute order authorizing therapy is required. All other services can be provided without court approval.**

H. ACTION (Complete appropriate section(s))

REFERRAL BEING MADE TO:	<input type="checkbox"/> Move from foster care to adoption <input type="checkbox"/> Support Adoptive Placement <input type="checkbox"/> Prevent adoption disruption	<input type="checkbox"/> COURT ORDERED
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EXHIBIT D-8

ADOPTION PROMOTION & SUPPORT SERVICES REFERRAL

Fax No. (213) 637-0040

I. GOALS: Please describe what goals you would like to see accomplished. *

EXHIBIT D-8

ADOPTION PROMOTION & SUPPORT SERVICES REFERRAL

Fax No. (213) 637-0040

J. SIGNATURES

	DATE

CSW SIGNATURE	
	DATE

SCSW SIGNATURE	
	DATE

APSS PROGRAM MANAGER SIGNATURE	

K. OFFICE USE ONLY

<input type="checkbox"/> NEW CASE		<input type="checkbox"/> AGENCY TO AGENCY TRANSFER	
APSS Agency Assigned		New APSS Agency Assigned	
SPA Location:	Select SPA	SPA Location:	Select SPA
Effective Date:		Effective Date:	
**Clients served:		Case Manager	
		Contact Info.	

More than One Agency Assigned

APSS Agency Assigned	
SPA Location:	Select SPA
Effective Date:	
*Clients served:	

* Please be sure to fill in Section I: Goals you would liked accomplished through this program.

**If more than one agency assigned to referral, indicate which clients are being served by each agency.

[Click to Access Spa/Zip Code Listing](#)

DCFS CORE PRACTICE MODEL

Our Departments have developed a shared and evolving model of practice to better integrate services and supports for children, youth, families and communities. Our commitment and approach are cemented in the crucial elements of community partnership, teamwork, family voice and choice, cultural competence, respect, accountability, continuous quality improvement and implementation of best practice.

Key Outcomes: *Safety, Permanence, Well-Being, Self Sufficiency, Organizational Excellence*

Shared Values and Guiding Principles

- **Child Protection & Safety:** Children and youth have the right to live in a safe environment, free from abuse, and neglect.
- **Permanent, Lifelong, Loving, Families:** Children and youth need and are entitled to a safe, nurturing and permanent family environment ideally in their own home.
- **Strengthening Child & Family Well-Being and Self Sufficiency:** Identifying the unique strengths of children, youth and families allows services and supports to be individualized and tailored.
- **Child Focused Family Centered Practice:** Focusing on the child's individualized, underlying needs and strengths, and the strengths and capacities of families provide the best guide to effective intervention and lasting change.
- **Community-Based Partnerships:** Services and interventions for children, youth and families are delivered collaboratively by agencies, providers, community and informal and naturally occurring supports in order to meet each family's needs.
- **Cultural Competency:** We maintain an attitude of cultural humility; honoring and respecting the beliefs and values of all families and recognizing that the cultural, ethnic and spiritual roots of the child, youth and family are a valuable part of their identity.
- **Best Practice and Continuous Learning:** We commit to developing an environment of continuous listening and learning and to ensuring that policy and

practice decisions are based on reliable data as well as evidence, research and feedback.

The Practice Wheel - Operationalizing the Shared Practice Model

Our values and guiding principles are applied through a set of practice activities depicted by the Practice Wheel.

- **Engaging** is the practice of creating trustful working relationships a child and their family by increasing their participation, validating their unique cultural perspective, and hearing their voice and choice.
- **Teaming** is the practice of building and strengthening the child and family's support system, whose members meet, communicate, plan together, and coordinate their efforts in a unified fashion to address critical issues/needs.
- **Assessing** is the practice of collaborating with a family's team to obtain information about the salient events impacting children and families and the underlying causes bringing about their situation.
- **Planning and Intervening** is the practice and process of tailoring and implementing plans to build on strengths and protective capacities in order to meet individual needs for each child and family.
- **Tracking, Adapting and Transitioning** is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, reworking the plan, celebrating successes, adapting to challenges and organizing

