	GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES CHILD WELFARE POLICY MANUAL			
	Chapter:	(10) Foster Care	**Effective Date:**	April 2020
	Policy Title:	Psychological and Behavioral Health Needs		
	Policy Number:	10.12	**Previous Policy #:**	N/A

CODES/REFERENCES

O.C.G.A. § 49-5-220 Legislative Findings and Intent; State Plan for the Coordinated System of Care for Severely Emotionally Disturbed Children or Adolescents
O.C.G.A. § 49-5-225 Local Interagency Committees; Membership; Function of Committees

REQUIREMENTS

The Division of Family and Children Services (DFCS) shall:

1. Refer each child five years of age and older for a trauma assessment within 10 calendar days of the child entering or re-entering foster care.
2. Collaborate with the Amerigroup Care Coordination Team (CCT) to refer a child to a licensed behavioral health provider for a behavioral health assessment if there is indication of a need for such an assessment.
3. Identify children with high risk behavioral health needs and follow the DFCS Teaming and Efficiency and Quality in Placement Matching Protocol to secure the appropriate services to meet the children's needs with assistance from the DFCS Care Coordination Treatment Unit.
4. Identify children with moderate risk behavioral health needs and collaborate with the Wellness, Programming, Assessment, and Consultation (WPAC) Unit to secure appropriate services to meet the children's needs.
5. Conduct monthly collateral contacts with behavioral health treatment providers and the Amerigroup CCT to obtain regular updates on children with behavioral health conditions requiring ongoing, regular care.
6. Provide medical and behavioral health information to the child's caregiver at the time of placement and on an ongoing basis.
7. Obtain authorization from the County Director prior to administering psychotropic medication to children in foster care, except in emergency situations. Authorization shall be provided to the prescribing physician within two business days of request.
   EXCEPTION: When children are receiving in-patient treatment (e.g. Crisis Stabilization Unit, Psychiatric Residential Treatment Facility), the consent decision is to be provided within 24 hours of the request from the facility.
8. Monitor the well-being of each child prescribed psychotropic medication:
   a. Document the name of each medication taken, the frequency, and the prescriber in Georgia SHINES.
   b. Review the medication log maintained by the caregiver during purposeful contacts to ensure the medication is being taken as prescribed.
9. Be available and responsive to any hospital or other entity providing hospitalization or treatment services to manage the behavioral health needs of children in foster care in accordance with policy 19.29 Case Management: Coordination of Care with Hospitals.

10. Refer each child being considered for treatment in a Psychiatric Residential Treatment Facility (PRTF) to the Local Interagency Planning Team (LIPT) for staffing.
11. Serve as a permanent team member of each LIPT and consistently have a local representative present at each meeting.

PROCEDURES

When a child enters foster care, the Social Services Case Manager (SSCM) will:

1. Engage the birth family, child, caregivers and collateral contacts to obtain as much information as possible and develop a full picture of the child's needs. Inquire as to whether the child has any emotional or behavioral problems, or if anyone has observed any of the following:
   a. Suicidal ideation, self-mutilating behaviors, and/or violence;
   b. Substance abuse, addiction, or prenatal exposure to substances:
      i. Does the child have any issues with substances? Which substances?
      ii. Has an alcohol and substance use assessment been completed? Who completed it? Results?
      iii. Has child been in substance use treatment or is currently in treatment? If so, where?
      iv. Date of last drug screen.
   c. Risky sexual behavior:
      i. Is child sexually active or promiscuous?
      ii. Is child using contraceptives? If so, which ones and who prescribed them?
      iii. Has the child had any pregnancies? What happened?
      iv. Does the child have any sexualized history? If so, what has been done to help them work through that?
      v. Has the child ever been sexually abused?
      vi. Has the child been treated for any sexual related health conditions?
   d. Indicators of sex trafficking (see Forms and Tools: Human Trafficking Case Management Statewide Protocol).
   e. Antisocial behavior;
   f. Frequent or uncontrollable angry outbursts;
   g. Excessive sadness and crying;
   h. Withdrawal;
   i. Lying or stealing;
   j. Defiance;
   k. Unusual eating habits, such as hoarding food or loss of appetite;
   l. Sleep disturbances;
   m. Changes in behavior at school, including truancy.
2. Collaborate with the Amerigroup CCT to ensure a child is referred for a trauma assessment within 10 calendar days of entering foster care as part of the Comprehensive Child and Family Assessment (CCFA) in accordance with policy 10.10 Foster Care: Comprehensive Child and Family Assessment.
3. For any child identified by the CCFA or any other assessment as having behavioral health, serious medical or developmental needs:
   a. Staff with the Social Services Supervisor and any other appropriate entities (e.g. Field Program Specialist, WPAC Unit, DFCS Care Coordination Treatment Unit). To the extent possible, the staffing should include the child's parent and current

caregiver to discuss assessment results and recommendations.

b. Collaborate with the Amerigroup CCT to refer a child to a licensed behavioral health provider for a behavioral health assessment as needed.
    i. Provide the evaluator sufficient background information on the child and family.
    ii. Obtain written information on the child's diagnosis and recommended treatment.
    iii. Ensure children receive the treatment necessary to meet their needs.
    iv. Update the child's Health Log under the Person Tab in Georgia SHINES immediately, but no later than 72 hours after receipt.
c. Follow the procedures established in the DFCS Teaming and Efficiency and Quality in Placement Matching Protocol to secure the appropriate services to meet the children's needs.
d. Contact the WPAC Unit for assistance in meeting the needs of a child with moderate risk behavioral health needs within two business days of identifying the need. Submit requests for well-being support from the WPAC Unit to healthmatters@dhs.ga.gov.
e. Attend and participate in LIPT meetings:
    i. Staff cases to ensure appropriate services are recommended;
    ii. Review and modify, as needed, decisions about placement of children and adolescents in out-of-home treatment or placement;
    iii. Monitor each child's progress.

4. Actively monitor a child's in-patient treatment:
    a. If possible, provide the in-patient treatment facility the Foster Care Individual Child Medication Log at admission;
    b. Develop a reintegration plan shortly after a child's admission into a treatment program;
    c. Review the individual plan for the child or adolescent and amend the plan if necessary;
    d. Ensure services are provided in the least restrictive setting and facilitate prompt return to the home setting when possible.
5. Provide medical and behavioral health information to the child's caregiver.
6. Update the child's Health Log, Case Plan and Log of Contacts in Georgia SHINES reflect monitoring of any behavioral health referrals and of the child's progress in responding to the services provided.

When a child is prescribed psychotropic medication, the SSCM will:

1. Review the Authorization of Psychotropic Medication for Children in Foster Care submitted by the prescribing physician.
    a. Contact the prescriber, if additional information is needed.
    b. Have a discussion with the parent, child and caregiver regarding the use of psychotropic medication (see Practice Guidance: Psychotropic Medication).
2. Obtain the County Director's decision to grant or deny consent and notify the prescribing physician of the decision within two business days of the request from the prescriber. If the County Director is unavailable, obtain consent from the Region Director.
    a. When children are receiving in-patient treatment (e.g. Crisis Stabilization Unit, Psychiatric Residential Treatment Facility), the consent decision is to be provided within 24 hours of the request from the facility.
    b. A medication consult may be needed with Amerigroup before the decision to grant or deny consent can be made.

c. If it is not possible to obtain written informed consent prior to starting psychotropic medication, verbal consent may be obtained from the DFCS County Director/Region Director. However, the Authorization of Psychotropic Medication for Children in Foster Care must be received by the DFCS County Director/Region Director and provided to prescribing physician no later than the next business day following the verbal consent.

EXCEPTION: Informed consent is not required when dealing with emergency circumstances such as suicidal ideation, severe psychosis, self-injurious behavior, physical aggression that is dangerous to self or others, or severe impulsivity that endangers self or others. Also, if psychotropic medications were initiated on an outpatient basis and the physician determines that withholding any medication can be detrimental to the patient's health.

3. If consent is granted:
   a. Scan completed/signed consent to the prescriber.
   b. Notify the parent, child and foster caregiver that consent was granted.
   c. Upload the consent form into Georgia SHINES External Documentation.
   d. Ensure the prescription is filled.
   e. Update the child's Health Log under the Person tab in Georgia SHINES.
4. If consent is not granted:
   a. Inform the prescriber of the decision by scanning the consent form with an explanation.
   b. Notify the parent, child and caregiver of the decision/reason and direct the caregiver to destroy the prescription slip.
   c. Work with the prescriber, parent, child and caregiver to establish an alternative treatment plan to address the needs of the child.
   d. Upload the consent denial into Georgia SHINES External Documentation.
5. Ensure the child's caregiver understands the requirements below and agrees to:
   a. Notify any prescriber of DFCS guidelines regarding consent.
   b. Take the medication consent documents received from DFCS to all the child's behavioral health appointments.
   c. Delay filling new prescriptions until consent is given by DFCS.
   d. Follow DFCS guidelines regarding the administration of psychotropic medications.
   e. Complete and continually update the Foster Care Individual Child Medication Log so that it always remains accurate and current. A Medication Administration Record (MAR) may be used by a Child Caring Institution (CCI) or Child Placing Agency (CPA) and is an appropriate substitute.

On an ongoing basis, the SSCM will:

1. Conduct at least one collateral contact with behavioral health providers each month to confirm that treatment is being provided and to obtain regular updates on the child's condition. This is applicable for children with behavioral health conditions requiring ongoing, regular care (see policy 19.16 Case Management: Collateral Contacts).
   a. Request therapy notes from the provider following each visit.
   b. Obtain written information on the child's diagnosis, treatment, medications, etc. and enter it in the child's Health Information page under the Person Tab in Georgia SHINES.
   c. Notify the DFCS Care Coordination Treatment Unit if there are problems obtaining notes from treatment providers.

2. Collaborate with the Amerigroup CCT to follow through with recommendations made by behavioral health providers within five business days for non-emergency issues.
   a. Emergency issues require immediate follow up.
   b. Notify the DFCS Care Coordination Treatment Unit of issues with collaborating with the CCT.
3. Discuss and review the medication log maintained by the caregiver during purposeful contacts with the child (when age and developmentally appropriate) and caregiver.
4. Consult with the child's parents, the child, and the caregivers regarding any concerns they have with any medication prescribed to the child. Document their responses.
5. Share the child's medical and behavioral health information with the caregiver and document that it was shared.
6. Ensure the following information for each child is current and present in Georgia SHINES:
   a. List of all prescribed medications;
   b. Authorization of Psychotropic Medication for Children in Foster Care (i.e. any existing forms authorizing the use of psychotropic medication signed by the County Director);
   c. Current trauma assessment, psychological evaluation or other behavioral health assessments;
   d. Documents related to behavioral health referrals;
   e. Therapy notes from treatment providers.
7. Inform the DFCS Care Coordination Treatment Unit or WPAC Unit of any Permanency Roundtables or staffing held for children with complex behavioral health needs and provide access to case information.

PRACTICE GUIDANCE

Psychotropic Medication

Psychotropic medications are drugs that affect the central nervous system by changing how the brain processes information. They can alter a person's mood, thoughts, perceptions, emotions and behaviors. It is important to remember that although medications can play a role in treating several behavioral health disorders and conditions, treatment may also include psychotherapy (also called "talk therapy") and brain stimulation therapies (less common). In some cases, psychotherapy alone may be the best treatment option. Choosing the right treatment plan should be based on a person's individual needs and medical situation. Treatment should always be provided under the care of a licensed behavioral health professional.

When children enter care with behavioral health needs that warrant the use of psychotropic medication, the parents are usually aware of the child's condition. Nevertheless, there should be a discussion with them as well as the child and the caregiver prior to authorizing the use of psychotropic medication for a child in DFCS custody. Even though DFCS may have the legal authority to authorize the use of psychotropic medication as part of a child's treatment plan, having the support of the parent, child and caregiver will contribute to the success of the treatment plan. Since there may be strong feelings for or against the use of psychotropic medication, skill must be exercised to build a consensus. If no consensus can be reached, respectfully inform all parties that DFCS must take the course of action determined to be in the best interest of the child.

When children are in a Crisis Stabilization Unit (CSU) or Psychiatric Residential Treatment Facility (PRTF), decisions regarding consent for the use of psychotropic medication must be made very quickly to avoid impeding a child's treatment. Therefore, consent should not be delayed by an inability to locate a parent or an inability to build a consensus with the parent, child and foster caregiver. Ideally, the discussion with the parent, child and caregiver should occur before the child requires in-patient treatment.

Behavioral Health Assessments

When a child enters foster care, it is extremely important to assess the child's psychological and behavioral health needs. There are various types of behavioral health assessments including Trauma Assessments, Psychological Evaluations, Psychiatric Evaluations, Psychosocial Evaluations, Substance Abuse Evaluation, etc. Each of these assessments must be completed by a licensed behavioral health provider. The Trauma Assessment serves as the baseline assessment for children five years or older entering foster care and can help identify whether other types of assessments are appropriate to meet the needs of a child.

Trauma Assessment

Trauma can affect many aspects of a child's life and may lead to secondary problems that negatively impact safety, permanency, and well-being (e.g., peer relationships, problems in school, health related problems). The Administration for Children and Families (ACF), a federal agency in the Department of Health and Human Services, has informed state child welfare agencies of the need to implement trauma-focused screening, assessment and treatment for children in foster care. The emotional well-being of our children is of the utmost importance and is directly correlated to their ongoing safety and success of permanency plans. The trauma assessment identifies all forms of traumatic events experienced directly or witnessed by a child to determine the best type of treatment for that specific child. In addition to the trauma history, trauma-specific evidence-based clinical tools assist in identifying the types and severity of symptoms the child is experiencing. Examples of evidence-based, trauma-specific clinical tools include:

1. UCLA PTSD Index for DSM-V
2. Trauma Symptom Checklist for Children (TSCC)
3. Trauma Symptom Checklist for Young Children (TSCYC)
4. Child Sexual Behavior Inventory

The trauma assessment must provide recommendations and actions to be taken by DFCS to coordinate services and meet a child's needs. Behavioral health providers who conduct a trauma assessment will provide a report which includes:

1. Trauma history, which informs the agency of information concerning any trauma the child may have experienced or been exposed to, as well as how they have coped with the trauma in the past and present
2. A standardized trauma screening tool
3. Summary and recommendations for treatment (if needed)

The inclusion of a trauma assessment as part of the CCFA does not mean there will not be situations in which other specialized assessment (e.g., psychological evaluations, psycho-sexual evaluations, psychiatric evaluations, neuropsychological evaluations, substance abuse assessments, psycho-educational evaluations, etc.) will be warranted. The decision to refer a

child for additional assessments must be made on a case-by-case basis in coordination with the CCT after an overall assessment of the child's needs has been completed. If it is determined that a psychological evaluation is needed, prior authorization must be obtained from Amerigroup for Medicaid to pay for it.

Psychological and Neuropsychological Evaluation

Psychological evaluations are not required for every child who enters care. However, the results of the trauma assessment may recommend a psychological evaluation. If so, the SSCM should collaborate with the Amerigroup CCT to refer a child to a licensed psychologist in-network. Amerigroup must provide prior authorization for any psychological evaluation; otherwise, Medicaid cannot be used to pay for the evaluation. Amerigroup will evaluate the medical necessity for the psychological evaluation based on the needs of the child and information already available. The Amerigroup CCT will coordinate any evaluation deemed necessary. For 24 Hour Emergency Assistance regarding behavioral health or addictive disease services, call 1-800-715-4225.

DFCS Care Coordination Treatment Unit

The DFCS Care Coordination Treatment Unit, formerly known as Placement Resource Operations (PRO), is one of eight units under the Placement and Permanency Section of DFCS. Requests for clinical services from the DFCS Care Coordination Treatment Unit may be submitted to cctu.support@dhs.ga.gov. The goals of the unit include:

1. Assisting DFCS youth with severe emotional disorders, developmental disabilities, intellectual disabilities, medical complexities, and/or addictive diseases, with gaining access to an appropriate system of care in their communities, ensuring that they have access to appropriate therapeutic and placement services;
2. Coordinating appropriate services for youth who will be discharged from a Psychiatric Residential Treatment Facility (PRTF) or Crisis Stabilization Unit (CSU) and returning to the community; and
3. Partnering with agencies to facilitate effective referral and screening processes that will ensure continuity of care.

<u>Target Populations</u>:

1. RBWO Program Designation children/youth: MWO-SMFWO
2. Severe Medically Complex
3. Substance Abuse & Human Trafficking (CSEC)
4. Specialized cases (populations) requiring out of state placement for treatment purposes, hoteling, 5+ placement disruptions and prevention cases
5. PRTF & Acute Hospitalizations
6. Emerging Dependent Adults 18-21 years old with I/DD, Severe MH, BH concerns

<u>Behavioral Support Specialists</u>

Behavioral Support Specialists within the DFCS Care Coordination Treatment Unit provide oversight and consultation for behavioral management issues for children in DFCS custody. They help DFCS field staff identify appropriate placement resources for children categorized as high-end with complex needs. They also provide additional support and oversight to RBWO providers to ensure that children are benefitting from therapeutic interventions and moving towards less restrictive placements

Therapeutic Support Specialists

Therapeutic Support Specialists within the DFCS Care Coordination Treatment Unit provide intensive practice guidance and consultation to field staff on cases that require a meticulous level of insight to navigate the complexities within our state systems, policies and regulations. These specialists are responsible for immediate and on-going assessment of medical necessity, treatment and discharge planning of inpatient admissions to a PRTF, CSU or other acute inpatient behavioral or physical health facility.

Wellness, Programming, Assessment, and Consultation (WPAC) Unit

The WPAC Unit provides practice support, consultation and quality monitoring of physical and moderate[1] behavioral health needs of children and youth in foster care. Specific functions of intensive support and monitoring include:

1. Training and consultation;
2. Performance monitoring;
3. Reviews, assessment and programmatic recommendations;
4. Data tracking and trend analysis;
5. Coordination and partnering during case staffing and case planning; and
6. Strategic coordination with community partners.

Local Interagency Planning Team (LIPT)

A LIPT should be established on behalf of children in each community. The team may be single or multi-county teams depending upon the size of the community and geographic availability of needed resources. The purpose for the development of the LIPT is to improve and facilitate the coordination of services to children with severe emotional disorders (SEDs) and addictive disease. LIPTs have the following goals:

1. To assure children with severe emotional disorders (SEDs) and addictive disease (ADs), and their families, have access to a system of care in their geographic area;
2. To assure the provision of an array of community therapeutic and placement services;
3. To decrease fragmentation and duplication of services and maximize the utilization of all available resources in providing needed services; and
4. To facilitate effective referral and screening systems that will assure children have access to the services they need to lead productive lives.

Georgia law requires permanent membership of the LIPT to include a local representative from each of the following agencies:

1. Department of Behavioral Health and Developmental Disabilities (DBHDD);
2. Division of Family and Children Services (DFCS);
3. The Department of Juvenile Justice (DJJ);
4. The Department of Public Health (DPH);
5. Georgia Vocational Rehabilitation Agency (GVRA);
6. Local education agency (i.e., Public schools' representative).

In addition to the permanent members, the local interagency committee reviewing the case of a child or adolescent may include, as ad hoc members, the special education administrator of the school district serving the child or adolescent, the parents of the child or adolescent, and caseworkers from any involved agencies.

[1] Less serious, severe, difficult, or extensive than others of the same kind

High Risk: Behavioral Health

"High risk" youth regarding behavioral health are those who have been designated as having a severe emotional disturbance or substance use/abuse. This would include:

1. A condition of severe emotional disturbance
    a. A mental or emotional disturbance listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM V);
    b. Adult diagnostic categories appropriate for children and adolescents:
        i. Substance related disorders;
        ii. Schizophrenia and other psychotic disorders;
        iii. Mood disorders;
        iv. Anxiety disorders;
        v. Somatoform disorders;
        vi. Dissociative disorders;
        vii. Sexual and gender identity disorders;
        viii. Impulse control disorders;
        ix. Adjustment disorders;
        x. Personality disorders.
    c. Disorders usually first evident in infancy;
    d. Childhood and adolescence disorders (including pervasive development disorders);
    e. Attention Deficit and disruptive behavior disorders;
    f. Tic disorders;
    g. Stereotypic movement disorder;
    h. Feeding and eating disorders;
    i. Separation anxiety disorder;
    j. Selective mutism and reactive attachment disorder.
2. Functional Symptoms and Impairment:
    a. Psychotic symptoms;
    Serious mental illness (e.g., schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions;
    b. Danger to self, other and property because of emotional disturbance:
    The individual is self-destructive (e.g., at risk for suicide, runaway, promiscuity, and/or at risk for causing injury to persons or significant damage to property).
3. Functional Impairment in two of the following capacities (compared with expected developmental level):
    a. <u>Self-care</u>- manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs;
    b. <u>Community</u>- manifested by a consistent lack of age appropriate behavioral controls, decision making and judgment, or involvement in the juvenile justice system;
    c. <u>Social Relationships</u>- manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults;
    d. <u>Family</u>- manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for the safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to confirm to reasonable limitations and expectations, which may result in removal from the family or its equivalent);
    e. <u>School and/or work:</u>
        i. Inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage, or violence

towards others);

ii. Inability to remain consistently employed at a self-sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job).

Moderate Risk: Behavioral Health

About one fourth of youth between10-17 years of age fall into the "moderate risk" category regarding behavioral health. They tend to be experimenters. They commit minor delinquent offenses and occasionally use illicit substances, but not hard drugs. They may also be one year behind in school.

Low Risk: Behavioral Health

About half of all young people fall into the "low risk" category regarding behavioral health. They do not commit any serious delinquent acts, do not use illicit substances, and are not yet sexually active. A small portion occasionally drink alcohol and a few are a year behind in school because of their birth dates or for developmental reasons. However, their risk for any significant negative consequences is minimal.

Hospitalization

When children require short-term, specialized hospitalization services to manage critical or immediate behavioral health needs, it is extremely important that DFCS staff is available and responsive to the hospital and treatment staff providing care to the children. In some cases, family members are not available to participate in treatment and support activities. Consequently, DFCS has the responsibility to fill in the gaps and ensure full engagement in the treatment process. Hospitals are places where children go to receive treatment and must not be viewed as foster care placements. Therefore, discharge planning should begin as soon as a child is admitted to a hospital or treatment facility. DFCS must ensure an appropriate placement option is available upon the child's release from the hospital so that the transition from the treatment facility to the placement occurs as smoothly as possible. Regardless of what day or time the discharge is scheduled to occur, a child should not be left in a hospital or facility after their treatment needs have been met.

Georgia Families 360˚

On March 03, 2014, the Georgia Department of Community Health (DCH) transitioned from a standard fee-for-service Medicaid program to a statewide Medicaid Care Management Organization (CMO) through Amerigroup Georgia Managed Care Company. The transition impacted children in DFCS custody and children receiving AA as they became members of a new program called *Georgia Families 360˚*. The new program is separate from *Georgia Families*, the general Medicaid program administered by DCH. *Georgia Families 360˚* is designed to provide coordinated care across multiple services and focus on the physical, dental, and behavioral health needs of member children. The program is designed to ensure each member has a medical and dental home, access to preventive care screenings, and timely assessments. It also seeks to ensure medical providers adhere to clinical practice guidelines and evidence-based medicine.

Amerigroup Care Coordination Team (CCT) and Care Managers

Each Georgia Families 360˚ member is assigned to a regional Care Coordination Team with a specified Care Manager. The Amerigroup CCT members are Masters level staff, most whom

hold a professional license to practice in their respective field. The Amerigroup CCT completes a Health Risk Screening (HRS) on youth in care to identify medical and/or behavioral health needs. It ensures each child is assigned to a behavioral health services provider as needed. The Amerigroup CCT is responsible for coordinating the health components of the Comprehensive Child and Family Assessment (CCFA), including the initial physical, dental, and trauma assessment.

Care Managers are the primary partner of the SSCM for identifying and making referrals for needed services. Care Managers ensure each youth has an individualized care plan that addresses both physical and behavioral health needs. They work with community agencies to ensure appropriate services are provided. Any services not authorized by the Amerigroup CCT will not be paid for out of Medicaid. Therefore, it is imperative that all behavioral health and developmental care be coordinated with the Amerigroup CCT to avoid any uncovered expenses. If a child is ineligible for Medicaid, then the Department of Behavioral Health and Developmental Disabilities (DBHDD) will provide behavioral health services to the child.

FORMS AND TOOLS

Authorization of Psychotropic Medication for Children in Foster Care
DFCS Teaming for Efficiency and Quality in Placement Matching Protocol
Foster Care Individual Child Medication Log
Guidelines for Psychotropic Medication Use on Children in Foster Care
Human Trafficking Case Management Statewide Protocol
Local Interagency Planning Teams (LIPT) Teams - Handbook
Psychotropic Medication Management - Consent Process Flow Chart
Psychotropic Medication Usage Parameters for Foster Children - Amerigroup