Appendix A

Surry County
Community Policy and Management Team (CPMT)

Agency	Title
Department of Social Services	Director
Surry County Public Schools	Superintendent
Sixth District Court Service Unit	Probation Supervisor
D19 Community Services Board	Manager, Children Services
Surry Health Department	Sr. Public Health Nurse
County Official	County Administrator or Designee
Parent Representative	Parent
Department of Youth and Family Resources Comprehensive Services	Director CSA Coordinator
Vendor Representative	Private Provider

Surry County
Family Assessment and Planning Team (FAPT)

Agency	Title
Department of Social Services	Senior Social Worker
Surry County Public Schools	School Social Worker
Sixth District Court Service Unit	Probation Officer
D19 Community Services Board	Children's Services Case Manager
Parent Representative	Parent
Department of Youth and Family Resources Comprehensive Services	Program Coordinator CSA Coordinator
Surry Sheriff's Department	Capitan or Designee
Surry Health Department	Public Health Nurse
Private Provider and/or Parent	Private Provider

Appendix B

SURRY COUNTY

CHILDREN'S SERVICES ACT (CSA) PROGRAM

Community Policy & Management Team
Tyrone Franklin, Chair

Family Assessment & Planning Team
Carolyn Lilly, Chair

CSA Coordinator
LaJeune Stone

Surry County
Children's Services Act
P.O. Box 65
Surry, VA 23883

I, _____, Agree to hold all information concerning clients of Surry County Family Assessment and Planning Team/ Community Policy and Management Team Confidential. I fully understand any information released by me must have prior approval from the Parent or Legal Guardian of the CSA FAPT Client and the CPMT/FAPT.

_____
Signature

_____
Date
Rev. 6/15

Rev. 6/15

Appendix C

Surry County CSA Coordinator (FULL-TIME POSITION)

GENERAL DESCRIPTION OF RESPONSIBILITIES:

Performs professional and administrative work to support the implementation of the Comprehensive Services Act (CSA) in Surry County. Position is responsible for ALL Fiscal Management of the CSA (Including administering grant funds and monitoring budgets. Collects and assembles data. Considerable accuracy and judgment is required.

EXAMPLES OF WORK:

- Responsible for all CSA clerical duties and coordinate meeting schedules and plan agendas for Surry CPMT and FAPT, Maintain confidentiality at all times
- Record and maintain all meeting minutes and related information, schedule case staffing and reviews, send notice letter to parent and/or vendor one week prior to meeting
- Distribute CSA information and other CSA-related items to appropriate teams and team members (i.e. training notices, grant notices, policy/procedure changes)
- Assist CSA Case Managers in compiling required CSA case information (i.e. Screening and Referral Packet for new cases, updated reports from vendors/providers, new and updated CANS Assessments, 90-day review info., etc.) Inform Case Manager of Utilization Management (UM) review date (case manager must complete UM review and CANS if necessary, any progress updates)
- Responsible for ELECTRONICALLY submitting Quarterly/Yearly Utilization Reports
- Responsible for submitting Quarterly/Yearly Reimbursement Reports, informing FAPT and CPMT of budget allocations monthly, update CSA Data Set as necessary
- Responsible for submitting necessary Supplemental Allocation Requests
- Responsible for tracking, reporting and projecting CSA Case Expenditures on a monthly and yearly basis and communicating information to the CPMT regularly
- Liaison between local and State CSA office when necessary; Liaison between local CSA and outside vendors/providers when necessary; Liaison between FAPT and CPMT when necessary
- Responsible for implementing the CANS and for serving as a Super user.
- Technical consultant to both the FAPT and CPM Teams regarding CSA policy and procedure
- Responsible for tracking and compiling bills for services rendered for CSA cases and preparing checks for signature by CSA Fiscal Agent and/or County Treasurer; Responsible for maintaining CSA ledger and fiscal folder regarding payments made for services rendered
- Assist Case Managers in preparing vendor contracts and purchase of service orders (i.e. responsible for ensuring that all contracts/agreements are signed and will monitor adherence to stipulations within the contracts; Document certification and licensure of providers to offer the needed services; secure evidence to ensure vendors have professional liability insurance for the services they provide.)
- If necessary, assist Case Managers in obtaining proper authorization for client services and assisting in implementing these services through the vendor/provider
- Establish and maintain updated list of all resources and service providers

KNOWLEDGE/SKILLS/ABILITIES:

Extensive experience with Microsoft Office, specifically Excel and Word; excellent typing skills to support correspondence, reports, and special projects; ability to organize and establish priorities. Most possess knowledge of internet and working in database systems. Ability to communicate in writing and possess excellent communication skills.

EDUCATION/TRAINING/EXPERIENCE:

College Degree in Human Services, Business Administration or related field preferred. Three (3) years of experience in government, or human services desired. Most possess office management skills, including computer skills and the ability to work with other agencies including governmental agencies, and other public/private organizations.

Reports To: The CSA Coordinator reports to the Director of Department of Youth and Family Resources and the County Administrator.

Surry County
Family Assessment and Planning Team
Assessment and Planning
Package

Appendix D

FAPT

Family Assessment Team
Criteria for Referral

Person referring the case: 1. Have You? (Please circle the appropriate response for each question)

Yes No N/A a. Referred the case to a mental health professional if there is a mental health issue? To whom _____ ? When _____?

Yes No N/A b. Referred the case to the Child Development Clinic, or other appropriate professional, if evaluations are needed?

Yes No N/A c. Referred the case for substance abuse assessment/treatment if needed?

Yes No N/A d. Referred the case to Social Services if abuse or neglect is suspected?

Yes No N/A e. Referred the case to the appropriate school professionals if there are school problems?

Yes No N/A f. Referred the case to the Health Department, or other appropriate medical professional, if there are medical problems?

Yes No N/A g. Obtained all the necessary information needed from the involved parties to present the case to the FAP Team?

Yes No N/A h. Made contact with all other professionals working with the child and family in an effort to coordinate services and /or treatment?

Yes No N/A 2. Have you staffed this case within your agency or with your supervisor?

3. What specifically do you want to come out of the FAP Team staffing?

_____
_____
_____
_____
_____

Yes No N/A 4. Have you obtained appropriate signatures on the Consent for Exchange of Information form?

5. List name/address of any individual other than parents who need notification of this meeting.

_____
_____
_____
_____

(Please add additional names on the reverse side)

Surry County
Family Assessment and Planning Team
Referral Form/Summary and Findings

Date of Referral _____ Leading Agency/Presenter _____

Date of Staffing _____ Court Ordered/Parental Consent attached (circle one)

1. Identifying Data

Name of Child _____ Address _____

Sex: _____ DOB: _____ Race: _____

Father/Step: _____ Age: _____ Mother: _____ Age: _____

Father's SSN: _____ Mother's SSN: _____

Address: _____ Address: _____

Phone # (___) _____ Phone # (___) _____

Employer: _____ Employer: _____

Education: _____ Education: _____

Siblings:

_____ Age: _____ _____ Age: _____

_____ Age:_____ _____ Age: _____

Significant Others: (Teachers, Scout leader, etc.): _____

2. Reason for referral: (include statement of presenting problem)

_____

_____

_____

_____

3. Steps taken to solve problem(s)/(previous problem): _____

_____

_____

_____

_____

4. Developmental, physical and medical information (Child and family) _____

_____

_____

_____

5. Educational and Vocational Information:

School: _____ Grade: _____

Special Needs/Services: _____

Attendance (Past and Present): _____

Performance (Past and Present): _____

Child's Employment: _____

6. Emotional and Behavioral Information (Child and Family):

7. Family Financial and Insurance Information:

8. Description of home and neighborhood:

(Please attach additional information as needed)

Surry County
Comprehensive Service Act Program

Individual Family
Service Plan

Name of Child: _____

Case Number: _____

Social Security #: _____

Parent's Name: _____ Home Phone(s): _____

Address(es): _____ Work Phone(s): _____

_____ _____

Original Staffing Date: _____

Follow-up Date: _____

Case Manager: _____

Referral Source:

[ ] DSS [ ] SHD
[ ] SHS [ ] SPS
[ ] MH [ ] Parent
[ ] Other: _____

Describe why the child needs services/placement:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Describe the strengths of the youth/family that may contribute to service delivery:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Individual Family Service Plan

Name: _____

Service Delivery

Service Objectives	Strategies	By: Stipulation	Begin Date	End Date	Progress

Progress Key: NI – Objective not initiated
C - Objective completed (Provide date)
P - Progressing on objective
NM –Objective not met
FC – Failed to complete objective (Attach written explanation)

Surry Assessment and Planning Team
Meeting Deliberations

Name of Child: _____ Case Number: _____

Reviews:

Date: _____ Recommendations

Case Plan Approved by:

_____	_____
Team Chairperson	Social Services Representative
_____	_____
School Representative	Health Department Representative
_____	_____
Court Services Representative	Parent Representative
_____	_____
Mental Health Services	Other (Specify)

Surry County
Children's Services Act Program
Confidentiality Agreement

As participants in The Community Assessment and Planning Team (CAP Team), we, the below signed, hereby agree to preserve the confidentiality of all information discussed at the staffing, held on this date _____ _____.

Signature	Title	Agency

Individual Family Service Plan

Name: _____

Rationale for Placement/Services: The Committee has considered the following:

- Placement /services based on youth's individual needs.
- Placement with age-appropriate peers
- Removal from the community only when nature or severity of youth's needs is such that services cannot be achieved satisfactorily.
- Placement/services provided as close as possible to youth's home.
- Any potential harmful effect on the child's social and personal needs as well as the youth's level of functioning or on the quality of services which is needed.
- Placement/services are most cost effective available to meet individual needs.

Participants:

Signatures of Participants	Agency Title	Date

Parent Participation:

Participated in the development of the IFSP? [ ] Yes [ ] No

Parent Permission:

I have been advised of the need for the placement/services described in this Individual Family Service Plan. I understand that I have the right to view my child's records and to request a meeting to review the placement/services at any time. I understand that I have the right to refuse permission and to have my child remain in his/her present placement pending further action. I [ ] give / [ ] do not give my permission to implement this plan.

_____ _____

Signature of Parent/Guardian Date

CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, _____, am signing this form for
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

_____
(FULL PRINTED NAME OF CLIENT)

_____
(CLIENT'S ADDRESS) *(CLIENT'S BIRTH DATE)* *(CLIENT'S SSN - OPTIONAL)*

My relationship to the client is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian
☐ Other Legally Authorized Representative

I want the following confidential information about the client *(except drug or alcohol abuse diagnoses or treatment information)* to be exchanged:

Yes	No		Yes	No		Yes	No	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits /Services Needed Planned, and/or Received	☐	☐	Medical Records	☐	☐	Criminal Justice Records
			☐	☐	Psychological Records	☐	☐	Employment Records

Other Information (write in):

I want: _____

_____
(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

And the following other agencies to be able to exchange this information:

Are More Agencies Listed on Back? YES ☐ NO ☐

I want this information to be exchanged ONLY for the following purpose(s):
☐ Service Coordination and Treatment Planning ☐ Eligibility Determination
Other (write in): _____

I want information to be shared: (check all that apply)
☐ Written Information ☐ In Meetings or By Phone ☐ Computerized Data

I want to share additional information received after this consent is signed: ☐ YES ☐ NO

This consent is good until: _____

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn.

I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information.

I want all the agencies to accept a copy of this form as a valid consent to share information.

If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

Signature(s): _____ **Date:** _____
(CONSENTING PERSON OR PERSONS)

Person Explaining Form: _____
(Name) *(Title)* *(Phone Number)*

Witness (If Required): _____
(Signature) *(Address)* *(Phone Number)*

5-14-92

032-01-005

UNIFORM CONSENT TO EXCHANGE INFORMATION FORM

FULL PRINTED NAME OF CLIENT:_____

FOR AGENCY USE ONLY

CONSENT HAS BEEN:

☐ Revoked in entirety

☐ Partially revoked as follows:

NOTIFICATION THAT CONSENT WAS REVOKED WAS BY:

☐ Letter (Attach Copy) ☐ Telephone ☐ In Person

DATE REQUEST RECEIVED:_____

AGENCY REPRESENTATIVE RECEIVING REQUEST:

_____

(AGENCY REPRESENTATIVE'S FULL NAME AND TITLE)

_____

(AGENCY ADDRESS AND TELEPHONE NUMBER)

5-14-92

032-01-005

County of Surry, Virginia
Comprehensive Services
Policy and Management Team
Vendor Contract Form

This Agreement is entered into by and between the County of Surry, Hereinafter "the Buyer", and _____, hereinafter "the Provider." The terms of this Agreement shall commence upon its full execution and shall continue in effect so long as services are to be provided to the client identified in the Addendum, attached hereto and made a part hereof, or until sooner terminated as herein provided.

WHEREAS the Buyer, through its Family Assessment and Planning Team, and with the approval of its Community Policy and Management Team, has determined that various services identified in the Addendum should be provided to the client; and

WHEREAS the Provider has established itself as a qualified provider of the services identified in the Addenda, has provided a complete description of those services to the Service Fee Directory, and meets all applicable State and Federal standards relative to the services to be provided hereunder;

NOW, THEREFORE, The parties hereto mutually agree as follows:

1. ADHERENCE TO LAW--This Agreement is subject to the provisions of relevant Federal, State and local law and regulation and any amendments thereof. This Agreement shall be governed in all respects, whether as to validity, construction, capacity, performance or otherwise, by the laws of the Commonwealth of Virginia.

2. SPECIFIC INTERPRETATIONS--The failure of the Buyer to enforce at any time any of the provisions of this Agreement, or to exercise any option which is herein provided, or to require at any time performance by the Provider of any of the provisions hereof, shall in no way affect the validity of this Agreement or any part thereof, or the right of the Buyer to thereafter enforce each and every provision. All remedies afforded in the Agreement shall be taken and construed
as cumulative, that is, in addition to every other remedy provided herein or by law. If any part, term, or provision of this Agreement is held by a court to be in conflict with any State, local or Federal law or regulation, the validity of the remaining portions or provisions shall be construed and enforced as if the Agreement did not contain the particular part, term or provision held to be
invalid.

3. PROVIDER'S DUTIES--The Provider shall provide all services specified in the attached Addenda. Any additional requirements not set forth in this Agreement, in the Addenda or other attachments hereto are provided as an addendum hereto entitled "Specific Requirements" and are incorporated herein.

4. ENTIRE AGREEMENT--Any documents, including the Addenda and the Specific Requirements Form referred to in this Agreement, are incorporated herein by reference as part of this Agreement. No other understandings, oral or written, are deemed to exist or to bind of the parties hereto in relation to the client identified in the Addenda. Any alterations, variations, modifications or waivers of provisions of this Agreement shall be valid and effective only when
they have been reduced to writing, signed by an authorized representative of the Buyer and of the Provider, and are attached to this Agreement. Where there exists any inconsistency between this Agreement and other provisions of collateral contractual agreements, which are made a part of this Agreement by reference or otherwise, the provisions of this Agreement shall control.

5. CHARGES AND DATES OF SERVICE PROVISION--The Provider shall charge the Buyer only for those services listed in the Addenda and at the rates established therein. The Provider shall provide the services commencing on the "Begin Date" and ending on the "End Date" set forth in the Addenda, unless extended by the written agreement of the parties.

6. SERVICE QUALITY--The Provider shall provide required services as described in the Addenda. Unless exempted, the Provider shall be listed in the Service Fee directory as authorized to receive payment from the state of pool funds under the Comprehensive Services Act and shall meet and maintain all State requirements for inclusion in that Directory. The Provider shall permit representatives authorized by the Buyer to conduct program and facility reviews in order to assess service quality. Such reviews may include, but are not limited to, meetings with consumers, review of service records, review of service policy and procedural issues, review of staffing ratios and job descriptions, and meeting with any staff

directly or indirectly involved in the provision of services. Such reviews may occur as often as deemed necessary by the Buyer and may be unannounced.

7. SERVICE CHANGES--Substantial changes in the proposed delivery of services from that stated in the Addenda, whether actual or anticipated, such as, but not limited to, changes in service quality, key personnel, and compliance with applicable State, local and/or Federal standards, shall be reported in writing to the Buyer within five calendar days.

8. REPORTS--The Provider shall submit written reports within 72 hours of staffing or team meetings to the Buyer indicating significant deviations from anticipated client progress as agreed by the Provider and Buyer. The Provider shall submit to the Buyer a written treatment plan [home visit report for foster care] and progress report regarding the client on the first business day of each month following service or more frequently at the request of the case manager and upon termination of service to the client. The treatment plan and progress report shall include at least the following information: short and long term goals, anticipated time of completion, prognosis, medications administered, progress or lack of progress of client, reasons for lack of progress, significant incidents or accidents and any past or planned special events. If the Provider fails to provide any written treatment plan or progress report in a timely manner, the Buyer may withhold payment of the Provider invoices pending receipt of such plan or report(s). The Provider shall provide the Buyer with a copy of any reports of physical examinations and psychological or psychiatric examinations of the client while under the care of the Provider.

9. REPORTING--The Provider will submit a monthly written report for each child enrolled, to the Buyer's case manager and CSA office. For children funded under Virginia Medicaid, a copy of the monthly written report submitted to Medicaid should also be submitted to the case manager and CSA office within the timeframes stipulated by Medicaid. For children funded by CSA, the report should be submitted within 10 days after the end of each month of service, and should include the information outlined in the Agreement for Purchase of Services, Section 8.

10. RECORDS MAINTENANCE--The Provider and any subcontractor shall maintain an accounting system and supporting records adequate to ensure that claims for funds are in accordance with applicable State, local and Federal requirements. The Provider also shall collect and maintain fiscal and statistical data on forms designated by the Buyer, if so requested. The Provider shall maintain all program records required by the Buyer. The Provider agrees to retain all books, records and other documents relative to this Agreement for five (5) years after final payment, or longer if necessary for the purposes of an unresolved State, local or Federal audit. The Buyer, its authorized agents, and/or State or Federal auditors shall have full access to and the right to examine any and all records during this period.

11. CONFIDENTIALITY--Any information obtained by the Provider concerning clients pursuant to this Agreement shall be treated as confidential. Use and/or disclosure of such information by the Provider shall be limited to the purposes directly connected with the Provider's responsibilities for services under this Agreement. It is further agreed by both parties that all client information shall be safeguarded in accordance with all applicable State and Federal laws and regulations.

12. CLIENT GRIEVANCES--In the event that a client or legal guardian registers a grievance, requests a fair hearing, or submits an appeal, the Provider, its agents and employees agree to appear on request of the Buyer in any proceedings arising from such a claim and provide all oral written information, and documentary evidence, within it's control relevant to such claim.

13. DISCRIMINATION--Neither the Provider, nor any subcontractor, shall discriminate against employees or applicants for employment or deny any individual any service or other benefit provided under this Agreement, pursuant to all requirements of the National Civil Rights Act of 1964, as amended, and any applicable State or Federal law or regulation.

14. HOLD HARMLESS--The Provider agrees to indemnify and hold harmless the Buyer from any and all claims for damages, either in law or in equity, directly or indirectly arising out of or by virtue of the actions or inactions of the Provider or its agents, servants, or employees in connection with this Agreement.

15. DISASTERS--Neither party hereto shall be held responsible for the delay or failure to perform hereunder when such delay or failure is due to acts of God, flood, severe weather, fire, epidemic, strikes, the public enemy, legal acts of public authorities or delays or defaults of public carriers, which cannot be forecast or provided against.

16. SUBCONTRACTS AND ASSIGNMENT--The Provider shall not enter into subcontracts for any of the services to be provided under this Agreement. Nothing in this Agreement shall be construed as authority for either party to make commitments that will bind the other party beyond the scope of services contained herein.

17. PROVIDER NOT BUYER EMPLOYEE--Neither the Provider nor its agents, employees, assignees or subcontractors shall be deemed employees nor agents of the Buyer while performing under this Agreement.

18. CHILD PROTECTIVE SERVICES INFORMATION--The Provider agrees that if the Provider or any of its agents, employees, assignees or subcontractors are named in the Child Protective Services Central Registry or through a criminal records check, then this information shall be made available to the Buyer and to any appropriate child placement and regulatory personnel of the Departments of Youth and Family Services, Education, Mental Health and Mental Retardation and the local department of social services.

19. BUYER TERMINATION OF PURCHASE INVOICE--The Buyer shall have forty five (45) calendar days from the date of the signature of the CSA representative in the Addenda to gain authorization of the CPMT. The CPMT retains the right to terminate or adjust this Agreement within those 45 days without penalty to the Buyer; however, the Buyer shall make payment for any services rendered during the forty five day period, subject to the terms of this Agreement. The Buyer's agreement in the Addenda may be adjusted or terminated at any time for client-related causes to include, but not limited to, changes in eligibility and changes in client's progress. The Buyer may terminate or adjust this Agreement for any reason upon forty five (45) days notice to the Provider. In the event that the Buyer becomes unable to honor this Agreement for causes beyond the Buyer's reasonable control, including but not limited to failure to receive promised revenue from Federal, State or local government sources or donor default in providing matching funds, the Buyer may terminate or modify this Agreement as necessary to avoid delivery of services for which the Buyer cannot make payment. The Buyer, upon becoming aware of any such cause, shall notify the Provider immediately.

20. PROVIDER TERMINATION OF THE ADDENDA FUNDS--After accepting the Addenda, the Provider may terminate service provisions only for just cause and only when a fourteen (14) calendar day advance written notice is given to the Buyer.

21. INVOICES--The Provider shall charge for services as provided in the Addenda. Such charges shall not exceed that set forth in the Service Fee Directory for the Provider appearing therein. The Provider shall not invoice the Buyer for a greater number of units of any service than that specified in the Addendum unless the Buyer specifically authorized in writing such increased units. The Provider shall invoice the Buyer only for services actually delivered. The Provider shall not submit any billings for services provided prior to the "Begin Date" or subsequent to the "End Date" shown in the Addenda, unless these dates are amended or extended by the parties in writing. The Buyer shall not be obligated to pay for services pursuant to authorized Addenda when the Provider fails to submit a Provider invoice for such services within forty-five (45) calendar days after the close of the calendar month in which services were delivered. Provider invoices, which are correct and are received by the Buyer by the first day of the month following services rendered shall be processed and paid no later than thirty (30) calendar days after the close of the next month. Those Provider invoices received later shall be processed and paid with the next month's Provider invoices. Provider invoices received that are not correct shall be returned to the Provider for correction.

22. PROVIDER FEES--No fee shall be imposed by the Provider upon the client served pursuant to this Agreement.

23. **PAYMENT THROUGH INSURANCE**--The Provider agrees to accept the family’s insurance (including CHAMPUS or its equivalent), or Virginia Medicaid or FAMIS for payment of services, provided that the Buyer obtains the permission and signature of the parent or legal guardian of the child. CSA will not fund services covered by the above forms of insurance if that insurance is made available to pay for services. When all or any portion of the services rendered by the Provider hereunder is covered by a policy of insurance or by CHAMPUS (or its equivalent), Medicaid, or FAMIS, the Provider shall submit claims for such service to the insurance company holding such policies or to CHAMPUS (or its equivalent), as the case may be. The Buyer shall pay the balance remaining due, if any, within forty-five (45) days after the Provider furnishes satisfactory evidence to the Buyer that the payment by the insurance company or CHAMPUS (or its equivalent) is the full amount. If the Provider receives Virginia Medicaid or FAMIS payments for services rendered under this Agreement, such payments shall constitute payment in full for those services.

24. INCORRECT PAYMENTS--If the Provider feels that the payment received for services invoiced is incorrect, then it is the Provider's responsibility to notify the Buyer in writing of the questionable payment. Supporting evidence must accompany such notification. The Buyer must correct any error found or respond in writing to the Provider as to why no error exists within forty-five (45) calendar days after receipt of the Provider's notification. If the Provider's notification and supporting evidence are not received by the Buyer within the forty-five (45)-calendar day limit, then the Buyer is not obligated to make any adjustments in the questionable payment. If the Provider believes that the payment received for services invoiced was an overpayment, the Provider must notify the Buyer immediately.

25. DISPUTES--Except as otherwise provided in this Agreement, any dispute concerning a question of fact arising under this agreement which is not disposed of by negotiation and agreement shall be decided by the Buyer's Fiscal Officer, who shall reduce his/her decision to writing and furnish a copy thereof to the Provider. This provision shall not preclude the Provider from exercising any rights under law for failure of the Buyer to comply with the terms of this Agreement.

26. PROVIDER BREACH--If the Provider fails to comply with any part of this Agreement, the Buyer may, by written notice of default to the Provider, terminate or revise the whole or any part of this Agreement and collect from the Provider any funds paid by the Buyer, which is related to the Provider's failure to comply.

IN WITNESS WHEREOF the parties have caused this agreement to be executed by officials hereunto duly authorized.

Important: The provider must attach other pertinent information to this contract that includes the Purchase of Services Order, Vendor Invoices, and brochures or service packets.

_____	_____
Authorized Representative of Provider	Surry CSA Coordinator
_____	_____
Title	CPMT Chairperson
_____	_____
Date	Date

PURCHASE OF SERVICES ORDER

VENDOR NUMBER:	VENDOR TAX ID NUMBER:	TYPE	PURCHASE OF SERVICE ORDER NUMBER	CASE NUMBER:
		☐ INDIVIDUAL		
VENDOR NAME:		☐ GROUP		CASE NAME:
		☐ REIMBURSEMENT		
ADDRESS:		☐ INTERNAL AUTHORIZATION	FUNDING SOURCE	ACTIONS
CITY, STATE, ZIP		MAIL INVOICES TO:		☐ NEW PURCHASE OF SERVICE ORDER
CLIENT NAME:	☐ ADULT ☐ CHILD			☐ NON-MONETARY CHANGE OF POSO #
ADDRESS:				☐ PREMATURE TERMINATION OF POSO #
CITY, STATE, ZIP				☐ UNENCUMBER NOW ☐ AWAIT FINAL VENDOR INVOICE ← COMPLETE IF PREMATURE TERMINATION IS CHECKED
TELEPHONE:				

SERVICE NAME	UNIT TYPE	EFFECTIVE DATE	TERMINATION DATE	UNIT PRICE	TOTAL UNITS AUTHORIZED	AUTHORIZED SERVICE BILLINGS
					TOTAL AUTHORIZED BILLINGS	

CASE WORKER NAME:	PHONE NUMBER
SIGNATURE OF CASE WORKER:	DATE APPROVED
SIGNATURE OF FISCAL OFFICER:	DATE APPROVED
SIGNATURE OF CASE SUPERVISOR:	DATE APPROVED

VENDOR: INDICATE ACCEPTANCE OR REFUSAL AND RETURN APPROPRIATE COPY TO THE LOCAL SOCIAL SERVICES AGENCY IMMEDIATELY.

☒ I HEREBY AGREE TO PROVIDE THE SERVICES REQUESTED ABOVE IN ACCORDANCE WITH OUR AGREEMENT FOR PURCHASE OF SERVICES OR INDIVIDUAL VENDOR AGREEMENT.

☐ I HEREBY REFUSE THIS PURCHASE OF SERVICES ORDER

I WILL PROVIDE THE SERVICES AS LISTED AND WILL SUBMIT THE VENDOR INVOICE WITHIN _____ WORK DAYS OF THE CLOSE OF THE MONTH IN WHICH SERVICES WERE PROVIDED.

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF VENDOR:	DATE:

032-02-0126-04-eng ☐ SEE ADDITIONAL SHEET

LOCAL DEPARTMENT OF SOCIAL SERVICES (2 COPIES)
VENDOR (1 COPY)

Appendix H

SURRY COUNTY

CHILDREN SERVICES ACT
CHECK REQUEST FORM

REFERRAL SOURCE
School System:_____
Mental Health: _____
Health Dept.: _____
Social Services: _____
Court Services: _____
Other:_____

AMOUNT OF REQUEST _____

TYPE OF SERVICE:

Mandated Services/Residential/Congregate Care

____ Foster Care-IV-E in Licensed Residential Congregate Care;
Pool expenditures for costs not covered by IV-E (i.e., non room-and board)
____ Foster Care- all others in Licensed Residential Congregate Care
____ Residential Congregate Care-CSA Parental Agreements; DSS Noncustodial Agreements
____ Educational Services-Congregate Care
____ School Referred Residential-Non Educational Services (Cannot have for first six months)

Other Mandated Services

____ Therapeutic Foster Care-IV-E
____ Therapeutic Foster Care
____ Therapeutic Foster Care-CSA Parental Agreements; DSS Noncustodial Agreements
____ Specialized Foster Care- IV-E; Community Based Services
____ Specialized Foster Care
____ Family Foster Care-IV-E; Community Based Services
____ Family Foster Care Maintenance only
____ Family Foster Care-Children receiving maintenance and basic activities payments; independent living Stipend/Arrangements
____ Community-Based Services
____ Community Transition Services-Direct Family Services to Transition from Residential to Community
____ Alternative Day Placement/SPED Private Day
____ Services in the Public School (Ex. Behavioral Aids)
____ Psychiatric Hospitals/Crisis Stabilization Units

Non Mandated Services
____ Non-Mandated Services/Residential Congregate
____ Non-Mandated Services/Community-Based

Vendor Name: _____
Address: _____
City/State/Zip: _____

Check Disposition: _____ Mail To: _____
_____ Pick Up By: _____

APPROVED FOR PAYMENT BY THE FAMILY ASSESSMENT TEAM:

_____, 20 _____ _____
CSA Coordinator

CASE NUMBER _____

CASE INITIAL _____

PUBLIC ____ PRIVATE _____

COMMUNITY PLANNING AND MANAGEMENT TEAM APPROVALS IS ONLY REQUIRED FOR ALL RESIDENTIAL PLACEMENTS THAT EXCEED A
MAXIMUM OF **$4,000** PER MONTH (AGGREGATE TOTAL) OR NON-RESIDENTIAL PLACEMENTS THAT EXCEED A MAXIMUM OF **$2,000** PER MONTH (AGGREGATE TOTAL).

APPROVED BY THE COMMUNITY PLANNING AND MANAGEMENT TEAM:

_____, 20 ____ _____
CHAIRPERSON

NOTE: ATTACH VENDOR INVOICE WITH CHECK REQUEST FORM.
DELETE CASE NAME AND DATE OF BIRTH FROM INVOICE.

CERTIFIED BY FINANCE DEPARTMENT: _____

DISTRIBUTION: ORIGINAL- CSA COORDINATOR
COPY-RETAINED BY F.A.P. TEAM CASE MANAGER

Revised 9/10/08

SURRY COUNTY
Community Policy & Management Team/Family Assessment & Planning Team

Parent Co-Payment Procedure:

The FAP Team is responsible for assessing and collecting Parental Co-payments, where parental or legal guardian financial contribution is not specifically prohibited by federal law or regulation, or has been ordered by the division of Child Support Enforcement.

Assessment and collection of co-payments are for all non-mandated services, utilizing the local approved income scale. When the family's income is beyond the income scale, 10% of the family's gross income shall be counted as the co-pay amount. A parental request for waiver of the co-payment or reduction of fee shall be based on CSA eligibility and parental availability to pay assessed by the FAP Team. Refusal to pay established co-pay without documented waiver may result in denial of services. Co-payments shall be reviewed at the time of case review.

State of Virginia
Monthly Median Income by Number in Family Unit

1	2	3	4	5	6	7	8	9	10
2,002	2,617	3,233	3,849	4,465	5,081	5,196	5,312	5,427	5,543

~Is the family's income at or below the median income level? Yes ____ No____
~If the family's income is at or below the median income level above, there is no co-payment required.
~If the family's income is above the median income level, use the worksheet below.

CO-PAY WORKSHEET

Case Name: _____ **Case Number:** _____

Number in Family Unit:	
Gross Monthly Income = A	**A =** _____
Percentage Of Income To Be Counted = B	**B =** _____
Amount Family Pays = C **(Multiple family gross monthly income by the % of income to be counted A x B = C)**	**C =** _____

_____/_____ _____/_____
Case Manager **Date** **FAPT Coordinator** **Date**

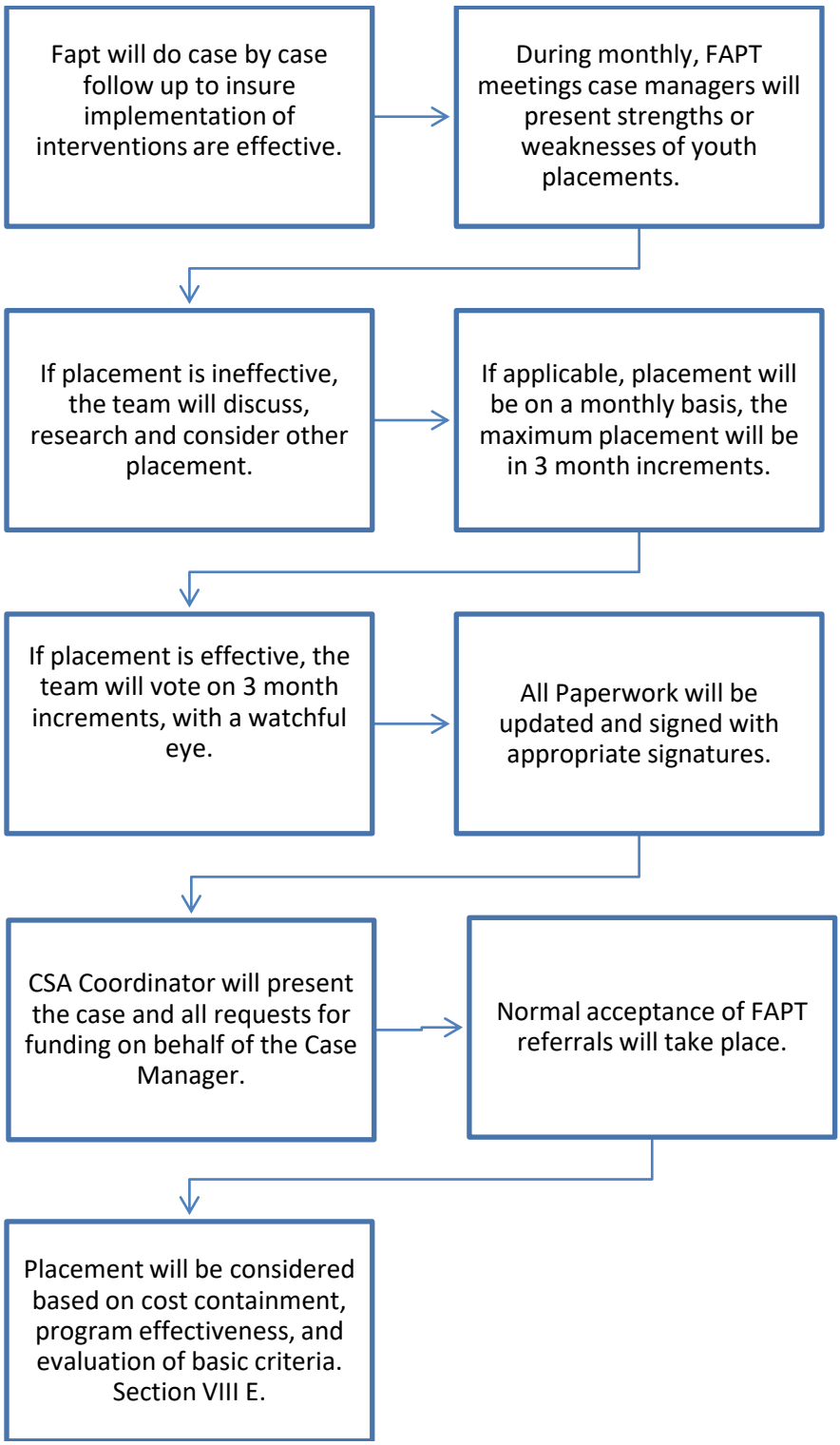
Virginia's Monthly Median Income Scale 10/01/2015 – 9/30/2016

See CSA Coordinator for the
Mental Health Referral Packet

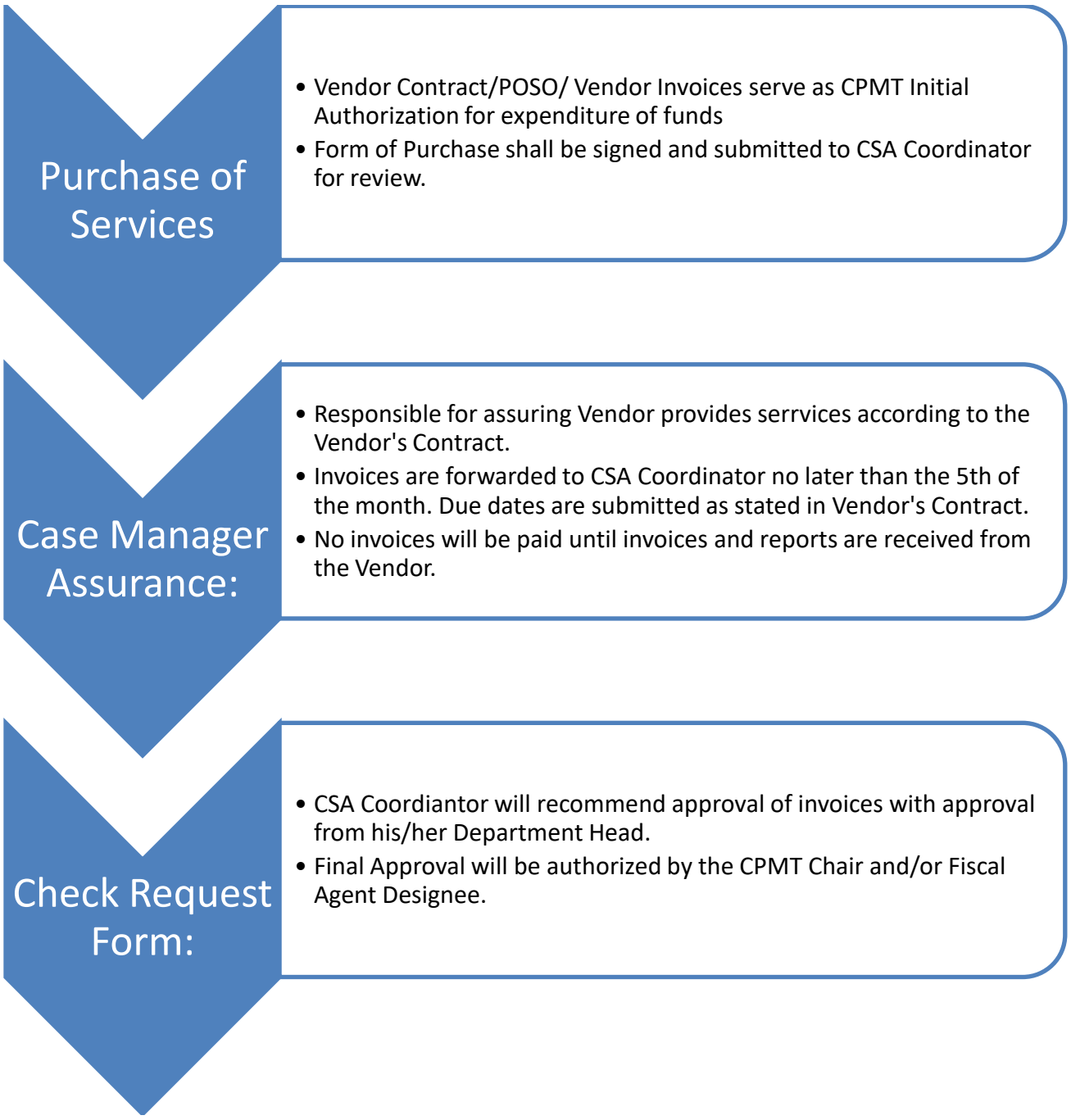
Surry County
Children's Services Act
For At Risk Youth

Process for UM

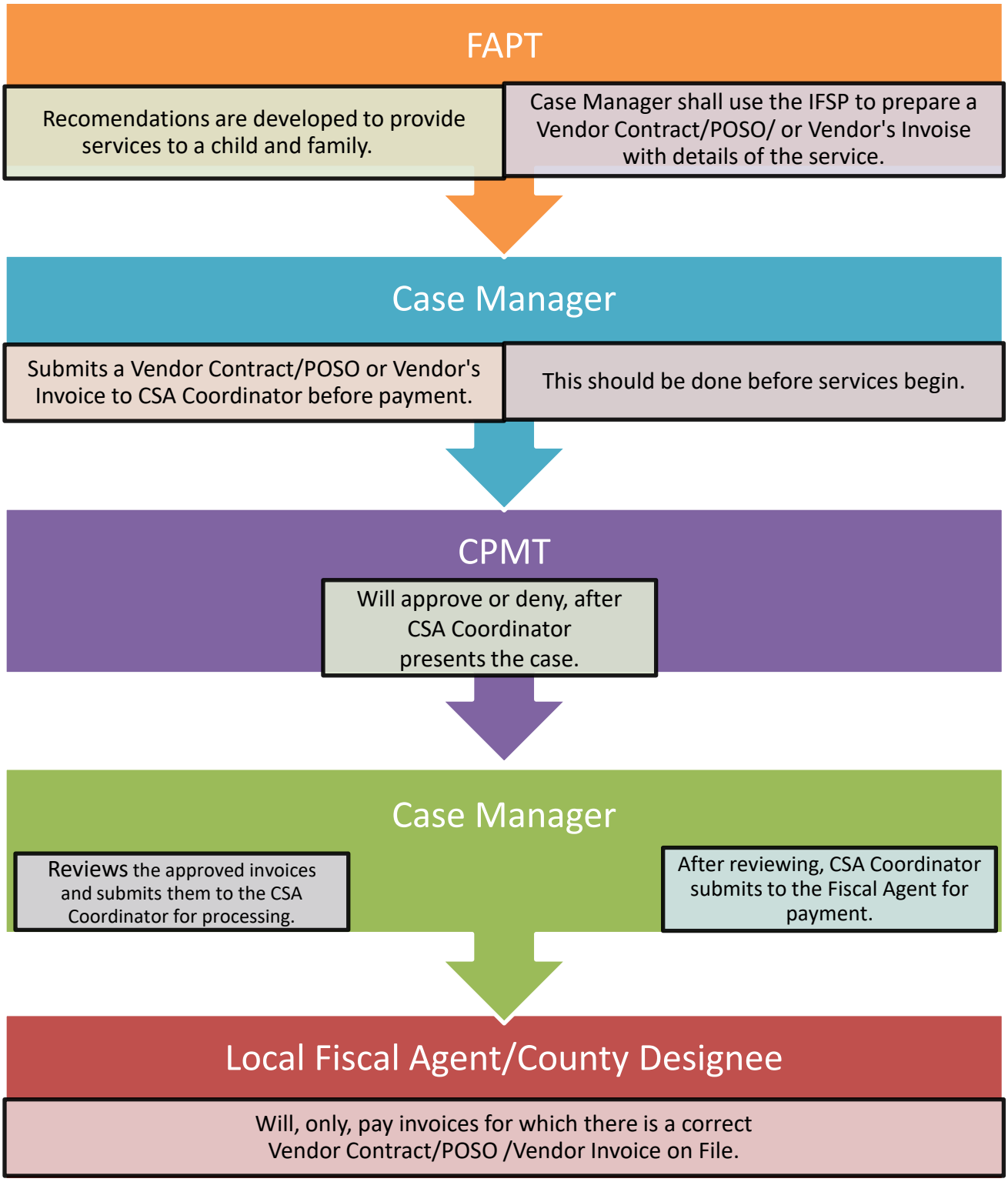
Process for UM



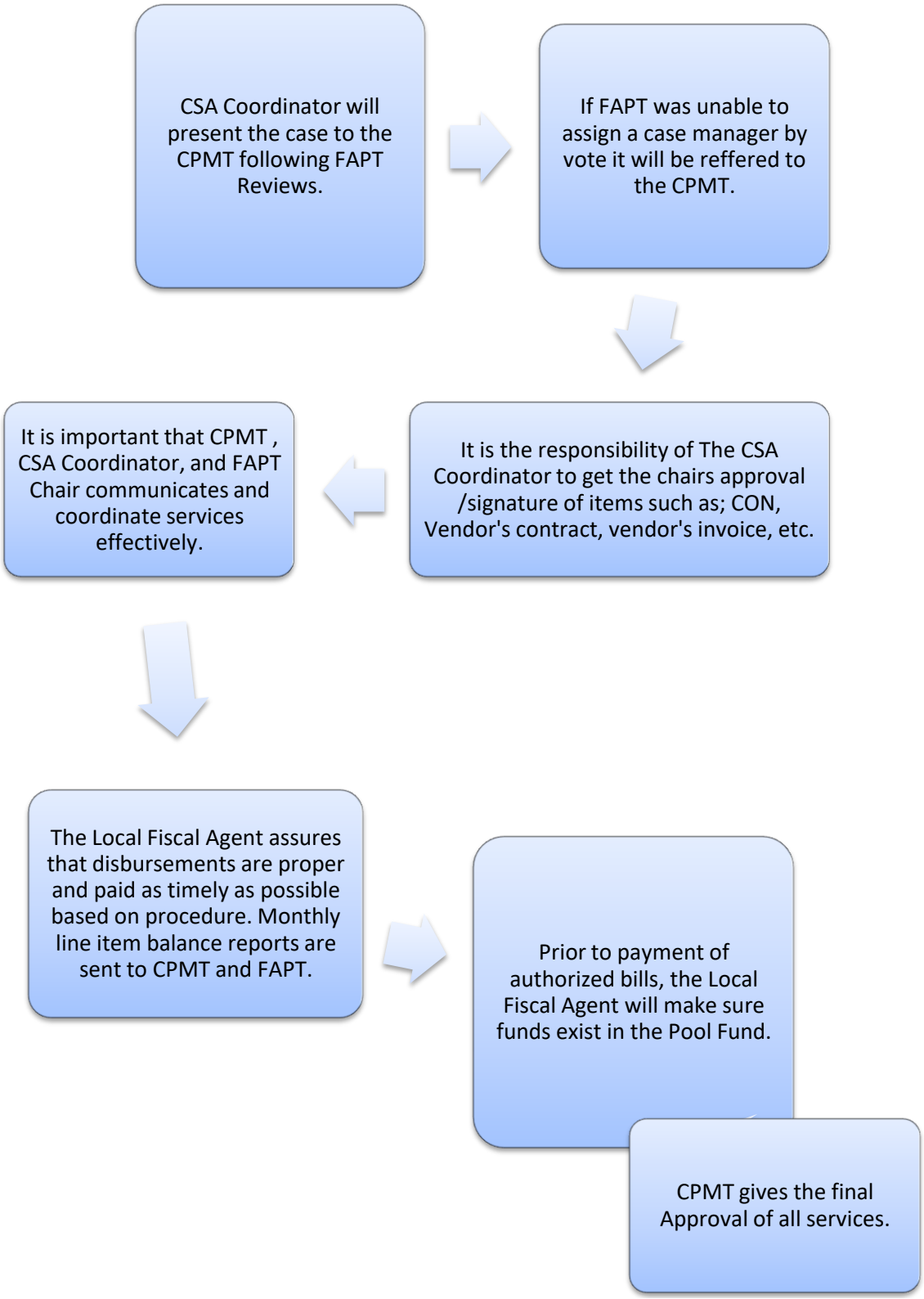
Payment of Services Process



Payment for Services



Process for CPMT Approval for FAPT Approved Services



Surry County CSA Intensive Care Coordination Plan

The CPMT and District 19 Community Services Boards shall work collaboratively to develop a local plan for intensive care coordination (ICC) services that best meets the needs of the children and families. District 19 CSB will provide CPMT with a listing of approved providers of ICC services for children in the community who are placed in or at-risk of being placed in, residential care through the CSA. District 19 case manager will be responsible for the ongoing monitoring of the ICC services provider for designated cases with periodic reports provided to the FAPT.

Definition of Intensive Care Coordination:

Intensive Care Coordination shall include facilitating necessary services provided to a youth and his/her family designed for the specific purpose of maintaining the youth in, or transitioning the youth to, a family-based or community based setting. Intensive Care Coordination Services are characterized by activities that extend beyond regular case management services that are within the normal scope of responsibilities of the public child serving systems and that are beyond the scope of services defined by the Department of Medical Assistance Services as "Mental Health Case Management."

Population to be served by Intensive Care Coordination:

Youth shall be identified for Intensive Care Coordination by the Family Assessment and Planning team (FAPT). Eligible youth shall include:

1. Youth placed in out-of-home care
    a. Level A or Level B group home
    b. Regular foster home, if currently residing with biological family and due to behavioral problems is at risk of placement into DSS custody
    c. Treatment foster care placement, if currently residing with biological family or a regular foster family and due to behavioral problems is at risk of removal to higher level of care
    d. Level C residential facility
    e. Emergency shelter (when placement is due to child's MH/behavioral problems)
    f. Psychiatric hospitalization
    g. Juvenile justice/incarceration placement (detention, corrections)

2. Youth at risk of placement in out-of-home care:

a. The youth currently has escalating behaviors that have put him or others at immediate risk of physical injury.

b. Within the past 2-4 weeks the parent or legal guardian has been unable to manage the mental, behavioral or emotional problems of the youth in the home and is actively seeking out-of-home care.

c. One of more of the following services has been provided to the youth within the past 30 days and has not ameliorated the presenting issues: Crisis Intervention; Crisis Stabilization; Outpatient Psychotherapy; Outpatient Substance Abuse Services; Mental Health Support.

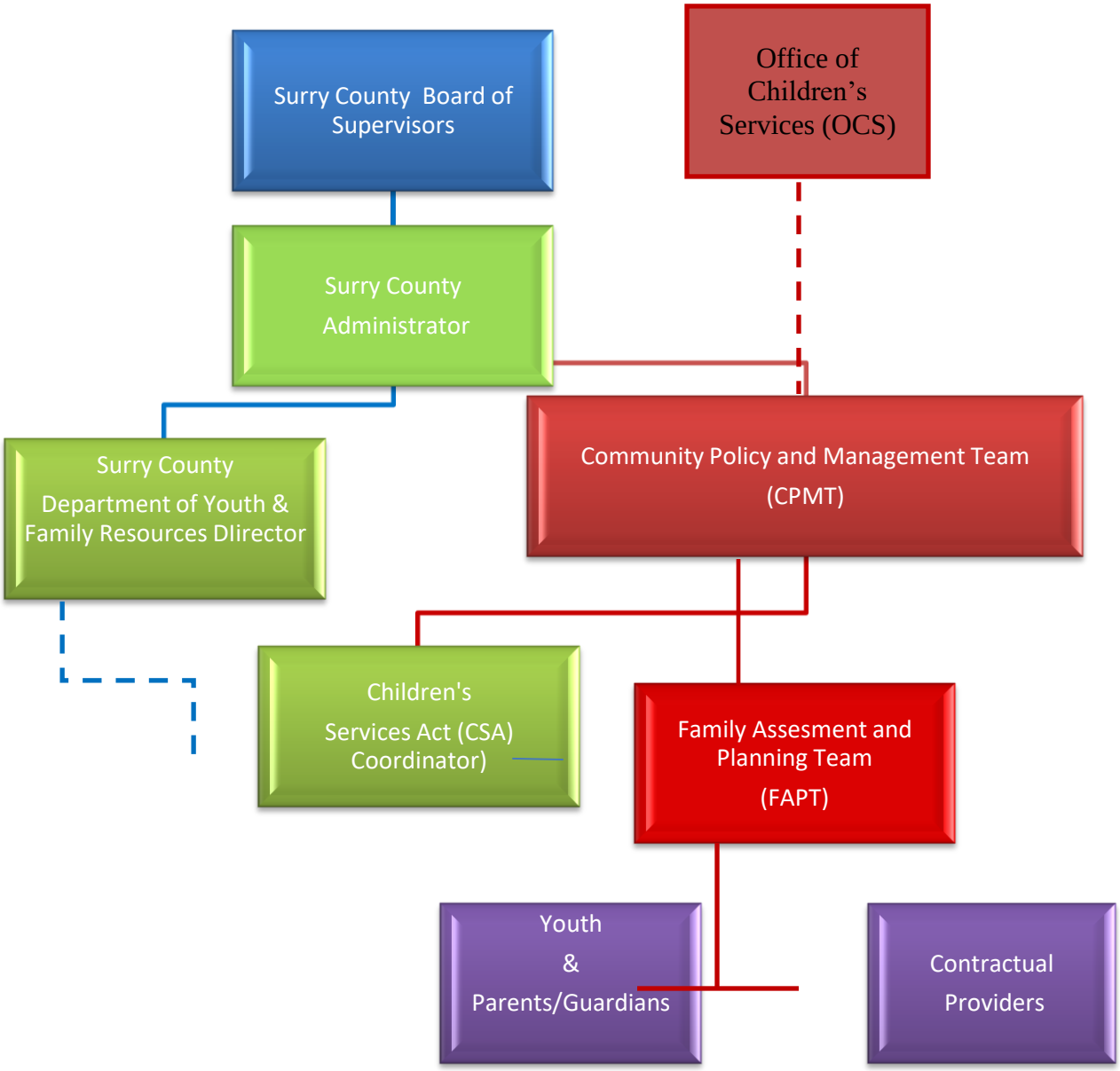
NOTE: Intensive Care Coordination cannot be provided to individuals receiving other reimbursed case management including Treatment Foster Care-Case Management, Mental Health Case Management, Substance Abuse Case Management, or case management provided through Medicaid waivers.

REFERRAL PROCESS FOR INTENSIVE CARE COORDINATION:

The CSA Case manager/Lead Agency representative will present the case for staffing at the FAPT. FAPT reviews the criteria listed above (see F. Intensive Care Coordination) to determine whether case is eligible for ICC services. If case meets eligibility criteria and the child is considered a viable candidate for ICC funded services, the CSA case manager will identify an approved provider from the CPMT approved provider listing and complete the referral process. FAPT will identify a District 19 case manager who will be responsible for the ongoing monitoring of the ICC service provider for the designated case with periodic reports provided to the FAPT.

Surry County
Children's Services Act
For At Risk Youth

Surry County
Children's Services Act Program



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