Service Standards

Family Foster Care and Kinship Care

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Definition

Family Foster Care and Kinship Care Programs work with parents, children, and caregivers to provide children with safe, stable, nurturing, and often temporary care in family settings, that promotes well-being and ensures strong connections with family, peers, and community. When children are separated from their families due to maltreatment or other family circumstances, services and supports are provided to facilitate reunification and stability and ensure that all children have permanent living arrangements as well as safe and nurturing relationships that will endure over time.

Family Foster Care is provided by foster parents who volunteer to bring children into their families and give them opportunities for family and community living. Foster parents are recruited, assessed, selected, credentialed, trained, and retained for this voluntary role. Foster parents always care for children in the custody of the local child welfare agency and serve as partners in child protection, well-being, and permanency.

Kinship Care is the full-time care of children by individuals who are (1) related to them by blood, marriage, or adoption; (2) members of their tribe or clan; or (3) recognized by the child, their parents, or other family members as having a significant emotional bond, often referred to as fictive kin. Kinship caregivers may provide care through arrangements made privately or informally in the family, or through arrangements made with the involvement and oversight of the local child welfare agency. In some jurisdictions or circumstances, kin may serve as licensed, approved, or certified resource parents. Kinship care builds on the strengths of family relationships. It ensures children's continued connections to their family networks and community supports while recognizing that the entire family (children, parents, and kinship caregivers) may need various services. Their natural role, the dynamics of family relationships, and the strengths and needs of kin require that organizations form strong collaborations with kinship caregivers to best promote permanency and the preservation of families.

Treatment Foster Care provides a therapeutic family environment and intensive clinical services for children whose medical, developmental, or psychiatric needs cannot be met in traditional family foster care, or who may be transitioning from a more intensive care setting, such as residential treatment, the juvenile justice system, or a hospital. With the support of a multidisciplinary treatment team, specially trained resource families provide nurturing care and treatment-based interventions that promote improved functioning. In some jurisdictions, treatment foster parents may be paid professionals, or kin may serve as treatment foster parents. Children may have: severe emotional or behavioral disturbances; physical or intellectual and developmental disabilities; severe or life-threatening illnesses; or conditions that require the routine use of a medical device and/or daily ongoing care or monitoring.

Transitional Foster Care programs for unaccompanied minors are short-term, licensed foster care programs housing children under the age of 18. These programs are an alternative to large shelters, and services are provided until children can be reunified with their families, a sponsor is identified, or in some cases, the child is moved to traditional foster care.

Standards Assignment Criteria

The Family Foster Care and Kinship Care Standards accommodate an array of programs that support and empower families when children require temporary care in a family environment, including:

- Family Foster Care Services
- Treatment Foster Care Services
- Foster to Adoption Services

- Family Foster Care Case Management Services
- Family Foster Care Home Services
- Formal and Informal Kinship Care Services
- Transitional Foster Care for Unaccompanied Minors

How the standards are applied and implemented will depend on the type of service and targeted service recipients, as well as the organization's role and responsibilities as defined by the local child welfare agency. Please refer to the Family Foster Care and Kinship Care (FKC) Standards Assignment Criteria Chart for a list of applicable standards by program model.

Interpretation: *Organizations should be familiar with the relevant legal requirements of the Indian Child Welfare Act (ICWA), which governs child welfare proceedings involving American Indian and Alaska Native children in state child welfare systems. To ensure compliance with ICWA, organizations must have established procedures for determining if children are members or eligible for membership in a federally recognized tribe, include tribal representatives throughout all aspects of service delivery in cases to which ICWA applies, and collaborate with local child welfare agencies to determine their role in the context of tribal-state child welfare agreements, ICWA, and any relevant state or tribal laws pertaining specifically to Indian child welfare.*

Note: *The following definitions apply throughout this section of standards:*

- *The term "children" includes infants, toddlers, school-age children, and youth, including youth in care after age 18. The term "youth" is used only when standards refer directly to services for older children, generally 14 years old and up.*
- *The terms "parent" and "family" typically refer to a child's birth parents and/or family of origin, but can also refer to anyone who is the child's guardian or primary caregiver prior to child welfare involvement. For example, while core concepts addressing "Services for Parents" and "Family Reunification" are typically for birth parents, they can also apply to other primary caregivers from whom the child was separated due to maltreatment concerns. "Parent" and "family" are also used to refer to adoptive parents and families and legal guardians in the core concepts that refer to expectations and supports for these families. However, the term "family" is typically not intended to include "resource families," which are defined separately below, except when referencing the extended family that may include related kinship caregivers.*
- *The term kin refers to individuals who are (1) related to the child by blood, marriage, or adoption; (2) members of their tribe or clan; or (3) recognized by the child, their parents, or other family members as having a significant emotional bond, often referred to as fictive kin.*
- *The terms "resource parent" and "resource family" refer to foster parents, kinship caregivers, and treatment foster parents. When standards address practice requirements relevant only to certain sub-groups of resource parents (e.g., kinship caregivers, or treatment foster parents), this is indicated in the language of the standard.*

Note: *Please see the FKC Reference List for the research that informed the development of these standards.*

Note: *For information about changes made in the 2020 Edition, please see the FKC Crosswalk.*

Table of Evidence

Self Study Evidence

No Self Study Evidence

Family Foster Care and Kinship Care

FKC 1: Person-Centered Logic Model

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

The organization implements a program logic model that describes how resources and program activities will support the achievement of positive outcomes for children and families.

Note: *Please see the Logic Model Template for additional guidance on this standard.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

Logic models have been implemented for all programs and the organization has identified at least two outcomes for all its programs.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Logic models need improvement or clarification; or
- Logic models are still under development for some of its programs, but are completed for all high-risk programs such as protective services, foster care, residential treatment, etc.; or
- At least one outcome has been identified for all of its programs.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Logic models need significant improvement; or
- Logic models are still under development for a majority of programs; or
- A logic model has not been developed for one or more high-risk programs; or
- Outcomes have not been identified for one or more programs.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- Logic models have not been developed or implemented; or
- Outcomes have not been identified for any programs.

Table of Evidence

Self Study Evidence

• Program logic model that includes a list of child and family outcomes being measured	
• See program description completed during intake	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Children and families served
    4. Resource parents

FKC 1.01

A program logic model, or equivalent framework, identifies:

a. needs the program will address;
b. available human, financial, organizational, and community resources (i.e. inputs);
c. program activities intended to bring about desired results;
d. program outputs (i.e. the size and scope of services delivered);
e. desired outcomes (i.e. the changes you expect to see in persons served); and
f. expected long-term impact on the organization, community, and/or system.

Examples: *Please see the W.K Kellogg Foundation Logic Model Development Guide and COA Accreditation's PQI Guide for more information on developing and using program logic models.*

Examples: *Information that may be used to inform the development of the program model includes, but is not limited to:*

1. *needs assessments and periodic reassessments;*
2. *risks assessments conducted for specific interventions;*
3. *the voices of children, families, resource families, and community partners;*
4. *the social and cultural context of the community served; and*
5. *the best available evidence of service effectiveness.*

FKC 1.02

The logic model identifies individual outcomes in at least two of the following areas:

a. change in clinical status;
b. change in functional status;
c. health, welfare, and safety;
d. permanency of life situation;
e. quality of life;
f. achievement of individual service goals; and
g. other outcomes as appropriate to the program or service population.

Interpretation: *Outcomes data should be disaggregated to identify patterns of disparity or inequity that can be masked by aggregate data reporting. See PQI 5.02 for more information on disaggregating data to track and monitor identified outcomes.*

Examples: *Child and family serving organizations interested in pursuing contracts with public entities may consider tracking outcomes that align with nationally recognized indicators of quality in the areas of prevention, safety, permanency, and well-being including, but not limited to:*

1. *percentage of cases in which placements remained permanent and stable;*
2. *percentage of cases in which family relationships and connections were preserved;*
3. *percentage of cases in which families were successfully reunified following out-of-home care;*
4. *percentage of children who transitioned to a less restrictive setting;*
5. *percentage of children with improved behavioral, social, cognitive, and/or physical functioning;*
6. *attainment of educational levels or milestones;*
7. *number of cases of recurring maltreatment;*
8. *number of cases of maltreatment-related fatalities; and*

9. *percentage of youth transitioning to youth with appropriate skills, permanent family resources, and support networks.*

Family Foster Care and Kinship Care

FKC 2: Personnel

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Program personnel have the competency and support needed to provide services that ensure the safety of children and promote the well-being of children and families.
Interpretation: *Competency can be demonstrated through education, training, or experience. Support can be provided through supervision or other learning activities to improve understanding or skill development in specific areas.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, including education, experience, training, skills, temperament, etc., but the integrity of the service is not compromised; or
- Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications; or
- Most staff who do not meet educational requirements are seeking to obtain them; or
- With few exceptions, staff have received required training, including applicable specialized training; or
- Training curricula are not fully developed or lack depth; or
- Training documentation is consistently maintained and kept up-to-date with some exceptions; or
- A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
- With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
- Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
- Specialized services are obtained as required by the standards.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- A significant number of staff (direct service providers, supervisors, and program managers) do not possess the required qualifications, including education, experience, training, skills, temperament, etc.; and as a result, the integrity of the service may be compromised; or
- Job descriptions typically do not reflect the requirements of the standards, and/or hiring practices do not document efforts to hire staff with required qualifications when vacancies occur; or
- Supervisors do not typically provide additional support and oversight to staff without the listed qualifications; or
- A significant number of staff have not received required training, including applicable specialized training; or
- Training documentation is poorly maintained; or
- A significant number of supervisors do not meet the requirements of the standard, and the organization makes little effort to provide training and/or consultation to improve competencies; or
- There are numerous instances where caseload sizes exceed the standards' requirements or the requirements of internal policy when a caseload size is not set by the standard; or
- Workloads are excessive, and the integrity of the service may be compromised; or
- Specialized staff are typically not retained as required and/or many do not possess the required qualifications; or
- Specialized services are infrequently obtained as required by the standards.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards.

Table of Evidence

Self Study Evidence

*	• Table of contents of training curricula	

*	• Procedures or other documentation relevant to continuity of care and case assignment	

*	• List of program personnel that includes:
	  • Title
	  • Name
	  • Employee, volunteer, or independent contractor
	  • Degree or other qualifications
	  • Time in current position
	• See organizational chart submitted during application	

*	• Procedures for peer mentor program, including for: recruiting, screening, training, and supervising mentors	

Site Visit Evidence

*	• Training curricula • Documentation tracking staff completion of required trainings and/or competencies • Sample job descriptions from across relevant job categories • Caseload size requirements set by policy, regulation, or contract when applicable • Documentation of current caseload size per worker

On-Site Activities

*	• Interviews may include:
	  1. Program director
	  2. Relevant personnel
	• Review personnel files

FKC 2.01

Workers are qualified by:

a. an advanced degree in social work or a comparable human service field; or
b. a bachelor's degree in social work or a comparable human service field with two years of related experience.

FKC 2.02

Supervisors are qualified by an advanced degree in social work or a comparable human service field and two years of experience working with children and families, preferably in family foster care or kinship care.
Interpretation: *Additional support in the form of monthly clinical consultation should be provided for supervisors in treatment foster care programs who do not have an appropriate advanced degree or sufficient experience.*

FKC 2.03

Workers are trained on or demonstrate competency to:

a. empower, support, and mentor parents and children;
b. respond to the diverse needs and characteristics of children in care including those related to race, ethnicity, culture, religion, sexual orientation, gender identity, and ability;
c. assess risk and safety;
d. conduct comprehensive assessments of strengths, needs, and protective factors;
e. collaborate with families to identify strengths and needs and develop effective service plans;
f. properly identify, engage, assess, and provide ongoing support for kinship caregivers, if applicable;
g. conduct well-planned, quality home visits that focus on issues pertinent to service planning;
h. understand child, adult, and family development and functioning, including child and adolescent brain development;

i. collaborate with different organizations, agencies, and systems likely to serve or encounter children and families, including the mental health, health, educational, and judicial systems;
j. evaluate progress on identified goals and the continued need for placement;
k. facilitate permanency, family connections, and community supports; and
l. follow the organization's protocols for responding to allegations of maltreatment in resource homes.

FKC 2.04

Workers who collaborate with resource families are trained on or demonstrate competency to:

a. recruit, assess, and engage with resource parents;
b. help resource families to meet the needs of the children in their care and provide a physically and psychologically safe, nondiscriminatory, and nurturing environment;
c. provide timely and responsive support to resource families; and
d. facilitate relationships between birth parents and resource families, when appropriate

Interpretation: *Personnel responsible for conducting resource parent assessments should receive initial and periodic training on how to conduct these assessments in order to reinforce the consistent application of the methods.*

FKC 2.05

Workers who support expectant and parenting youth are trained on or demonstrate competency to:

a. present information in a manner that will resonate with expectant or parenting youth;
b. address the dual developmental needs of adolescents and young children;
c. promote youths' transition to adulthood while parenting; and
d. facilitate father involvement when appropriate and feasible.

NA: The organization does not serve youth 14 and older.

FKC 2.06 (FP)

Workers and supervisors, depending on job responsibilities, are trained on or demonstrate competency to implement relevant provisions of the Indian Child Welfare Act (ICWA), including:

a. the importance of ICWA and special considerations for working with American Indian and Alaska Native children;
b. the identification of American Indian and Alaska Native children;
c. determination of jurisdiction;
d. appropriate notice and collaboration with the child's tribe;
e. placement preferences that support the child's connection to their native culture and heritage;
f. active efforts requirements to reunify families; and
g. court procedures.

NA:

- The organization provides kinship care services only.
- The organization provides services for foreign-born children only.

Interpretation: *All child welfare personnel should be trained in the basic requirements of ICWA and informed of the cultural norms and historical trauma associated with Indian tribes and staff in specialized service units (e.g. intake or permanency planning) should receive additional specialized training. All screening personnel must be trained on how to identify children with American Indian or Alaska Native heritage.*

FKC 2.07

The organization minimizes the number of workers assigned to the family over the course of their contact with the organization by:

a. assigning a worker at intake or early in the contact; and
b. avoiding the arbitrary or indiscriminate reassignment of direct service personnel.

Examples: *Organizations can strive to minimize the number of workers assigned to the family by, for example: (1) examining any policies or procedures that require families to be passed from one specialty worker to another as they move through the system; (2) addressing factors that may contribute to personnel turnover (e.g., by ensuring caseloads are reasonable and providing appropriate training, supervision, and support); and (3) establishing transition procedures for internal turnover (e.g. limiting reassignment of cases due to promotions or other role changes).*

Organizations providing both traditional and treatment foster care can promote continuity during level of care transitions by instituting:

1. *blended caseloads;*
2. *cross-training; and/or*
3. *team lead or dyad supervision models.*

FKC 2.08 (FP)

Employee workloads support the achievement of positive outcomes for families, are regularly reviewed, and generally do not exceed:

a. 12-15 children in foster care or kinship care, and their families; and
b. 8 children in treatment foster care, and their families.

Interpretation: *When workers manage a blend of case types, caseloads should be weighted and adjusted accordingly. Caseloads may be higher when organizations are faced with temporary staff vacancies. New personnel should not carry independent caseloads prior to the completion of training.*

Interpretation: *For programs that exclusively serve resource families, such as in foster care home services or informal kinship care, this standard will be evaluated based on whether the assigned workload is manageable for personnel, taking into account the factors cited in the standard and examples. Each organization should determine what caseload size is appropriate, and reviewers will evaluate: (1) whether the organization's designated caseload size reflects a manageable workload, and (2) whether the organization maintains caseloads of the size it deemed appropriate.*

Examples: *Factors that may be considered when determining employee workloads include, but are not limited to:*

1. *the qualifications, competencies, and experience of the worker, including the level of supervision needed;*
2. *the work and time required to accomplish assigned tasks and meet practice requirements, including those associated with individual caseloads and other organizational responsibilities;*
3. *service elements provided by other team members or collaborating providers; and*
4. *service volume, accounting for the complexity and status of each case, including intensity of child and family needs, size of the family, and the goal of the case.*

FKC 2.09

The organization prevents and counters the development of secondary traumatic stress by:

a. helping personnel develop the skills and behaviors needed to manage and cope with work-related stressors;
b. encouraging respectful collaboration and support among co-workers; and
c. examining how the organization's culture and policies contribute to or prevent the development of secondary traumatic stress.

Examples: *Organizations can support workers by helping them to: develop the skills and behaviors that will enable them to engage in positive thinking; increase their self-awareness; know their limits and needs; establish healthy boundaries; monitor and regulate their emotions and behaviors; identify and manage emotional triggers; and take time for self-care. Regarding element (c), areas to consider include but are not limited to: supervision, caseload assignment, scheduling, and crisis response.*

FKC 2.10

When peer mentors provide support to birth parents or resource parents, the organization:

a. clearly defines the role and responsibilities of the mentors;
b. establishes guidelines for recruitment of prospective mentors, including how much time must elapse before a former client is eligible for the role;
c. carefully screens prospective mentors to ensure they are a good fit for the program;
d. trains mentors to fulfill their role; and
e. provides ongoing support and supervision to ensure that mentors have the skills they need, address any issues that arise, and respond to signs of trauma among peer mentors.

NA: The organization does not use peer mentors to provide services.

Interpretation: *Peer mentor training should address:*

1. *setting appropriate boundaries;*
2. *protecting confidentiality and privacy;*
3. *managing personal triggers that may occur in the course of their role as a peer mentor; and*

4. *recognizing and responding to a mentee's need for more intensive services, as appropriate to the role.*

Examples: *Responsibilities of peer mentors may include: providing non-judgmental social and emotional support; facilitating family engagement in services; helping families understand and navigate the child welfare system, foster parent certification process, or adoption process; connecting families to needed resources; helping families advocate appropriately for themselves; and/or supporting recruitment and outreach efforts to prospective resource families.*

Family Foster Care and Kinship Care

FKC 3: Initial Assessment

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

The organization conducts prompt and responsive initial assessments to determine if the program can meet the needs of children and families, and provides alternative service recommendations if needed.
Interpretation: *Because organizational roles in the initial assessment process are dependent on referral systems and contractual obligations, organizations should provide procedural or documentary evidence that demonstrates implementation of the standards.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- In a few rare instances, urgent needs were not prioritized; or
- For the most part, established timeframes are met; or
- Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Urgent needs are often not prioritized; or
- Services are frequently not initiated in a timely manner; or
- Applicants are not receiving referrals, as appropriate; or
- Assessment and reassessment timeframes are often missed; or
- Assessments are sometimes not sufficiently individualized;
- Culturally responsive assessments are not the norm, and this is not being addressed in supervision or training; or
- Several client records are missing important information; or
- Client participation is inconsistent; or
- Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- There are no written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Initial assessment and intake procedures	
*	• Admission policy	
*	• Procedures for identification of children with American Indian and Alaska Native heritage and collaboration with tribes on ICWA cases	

Site Visit Evidence

*

- Copies of tribal-state agreements, when applicable
- Community resource and referral list

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Children and families served

- Review case records

FKC 3.01

Organizations maintain an admission policy that includes:

a. steps and requirements for admission;
b. prohibition of discriminatory selection processes; and
c. reasons the program may decline referrals.

NA: The organization: (1) accepts all clients, or (2) only receives clients by referral, and is required by contract to accept all referrals.

FKC 3.02

Prompt, responsive initial assessment practices:

a. give priority to urgent needs and emergency situations;
b. support timely initiation of services; and
c. ensure that referral sources are notified immediately if services cannot be provided or cannot be provided promptly.

NA: The organization is not responsible for initial assessment.

FKC 3.03

During intake, the organization:

a. gathers information necessary to identify critical service needs and/or determine when a more intensive service is necessary; and
b. conducts an assessment of children's risk of harm to self or others that is used to inform decision-making, identify appropriate resource families, and develop safety plans with parents and resource families.

FKC 3.04 (FP)

The organization identifies American Indian and Alaska Native children and has a process to ensure outreach and collaboration with the tribe or Indian organization to:

a. determine jurisdiction;
b. ensure compliance with the Indian Child Welfare Act;
c. provide families with information regarding their rights under the Indian Child Welfare Act;
d. facilitate their participation in assessment and service planning to determine the most appropriate plan for children and families; and
e. maintain connections between children, their extended family, and their tribes.

NA:

- The organization provides kinship care services only.
- The organization provides services for foreign-born children only.

Interpretation: *The organization should have established procedures for identifying American Indian and Alaska Native children to determine if the child or his/her biological parent(s) are members of a federally recognized tribe, or if the child is eligible for membership in a federally recognized tribe. Physical appearance, blood quantum, and perceived presence or absence of cultural cues within the family, are not appropriate determinants of ICWA applicability. The organization should document efforts to identify and contact children's tribes, and if tribes are unknown, the organization should contact the regional office of the Bureau of Indian Affairs to identify, locate, and notify the child's tribe.*

Family Foster Care and Kinship Care

FKC 4: Comprehensive Assessment

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Children, parents, and resource families are engaged in an individualized, strengths-based, and culturally responsive comprehensive assessment process that guides supports, service, and permanency planning.
Interpretation: *When the organization receives an assessment from another provider this assessment should contain all components identified within the standards or the organization should use a supplemental assessment that satisfies the standards and provides additional opportunities to engage with and learn about children and families.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- In a few rare instances, urgent needs were not prioritized; or
- For the most part, established timeframes are met; or
- Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Urgent needs are often not prioritized; or
- Services are frequently not initiated in a timely manner; or
- Applicants are not receiving referrals, as appropriate; or
- Assessment and reassessment timeframes are often missed; or
- Assessments are sometimes not sufficiently individualized;
- Culturally responsive assessments are not the norm, and this is not being addressed in supervision or training; or
- Several client records are missing important information; or
- Client participation is inconsistent; or
- Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- There are no written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Assessment procedures	
*	• Copy of assessment tool(s)	

Site Visit Evidence

*
- Regulatory or administrative requirements that define intervals for assessments, if applicable

On-Site Activities

*
- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Children and families served
- Review case records

FKC 4.01

Families participate in an individualized, strengths-based, and culturally and linguistically responsive assessment that:

a. is completed within established timeframes;
b. engages all immediate family members;
c. includes the child and family's telling of their own story;
d. identifies and involves extended family and other supports whenever possible; and
e. explores individual and family functioning over time, including family competencies and resources and times families successfully managed challenging situations.

Interpretation: *The assessment process should be initiated through individual meetings (1) with children within the first 72 hours of initial placement or any subsequent placements; (2) with parents within the first two weeks of placement; (3) with resource parents within the first two weeks of placement; (4) with children in treatment foster care as part of the admission process on the day of placement; and (5) with treatment foster parents within 10 days of placement.*

Interpretation: *The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design.*

Examples: *The assessment process should be adapted based on the characteristics and needs of families, as necessary and appropriate. For example, strategies for family engagement should account for and accommodate family histories, particularly when kin are caring for children.*

When the organization is working with an American Indian or Alaska Native family, tribal representatives or other tribal community members must be involved in the assessment process, as determined by the tribe and the family; the process for engaging family members should be adapted to protect the safety of domestic violence victims, as needed; and if fathers are absent the agency should make a diligent attempt to locate them.

Family participation in the assessment process may not be possible when the organization is serving children with limited family involvement or unaccompanied minors.

FKC 4.02 (FP)

Assessments explore parents' strengths, needs, and functioning related to the following areas and their impact on parenting capacity:

a. family relationships, dynamics, and functioning, including any history of or exposure to domestic violence or human trafficking;
b. informal and social supports, including relationships with extended family and community members, as well as connections to community and cultural resources;
c. trauma exposure and related symptoms;
d. ability to meet basic financial needs and obtain adequate housing, food, and clothing;
e. physical health, including any chronic health problems;
f. substance use;
g. emotional stability, including mental health, adjustment, and coping abilities;
h. parenting skills; and
i. disciplinary practices.

NA: The organization, by virtue of law or contract, does not serve parents.

Interpretation: *Standardized and evidence-based assessment tools are recommended to inform decision-making in a structured manner and objectively gather data across cases.*

Regarding element (c), the expectation of this standard is that personnel will conduct a screening to identify trauma exposure and reactions, and arrange for a follow-up trauma-focused assessment when needed. Clinical trauma assessment must be provided by appropriately trained clinicians.

FKC 4.03

Assessments explore children's strengths, needs, and functioning related to the following areas:

a. physical health, including any chronic health problems;
b. emotional stability and adjustment;
c. behavior, including any risk of harm to self or others;
d. education and cognitive development, including school readiness;
e. family relationships, including with siblings and kin;
f. informal and social supports, including relationships with adults and peers in the extended family and community, as well as connections to community and cultural resources;
g. substance use;
h. trauma exposure and related symptoms;
i. gender identity and sexual orientation; and
j. any history of or exposure to domestic violence or human trafficking.

NA: The organization does not provide case management services for children.

Interpretation: *Regarding element (i), when exploring gender identity and sexual orientation personnel should ask open-ended questions that prompt discussion and help establish rapport, as opposed to asking direct questions. Information shared should be used to inform service planning, as well as for matching children with resource families they may be able to join, when appropriate, and should only be included in written plans when children give explicit consent.*

Examples: *Several tools are available to help identify a potential victim of human trafficking and determine next steps toward an appropriate course of treatment. Examples of these tools include but are not limited to: the Rapid Screening Tool for Child Trafficking and the Comprehensive Screening and Safety Tool for Child Trafficking.*

FKC 4.04 (FP)

Assessment is ongoing and formal re-assessments of strengths, needs, risk, and safety are conducted with families periodically, including:

a. as part of case reviews;
b. for decision making processes; and
c. when children's or families' circumstances change.

Interpretation: *To prevent unnecessary placement changes and ensure placement in the least restrictive setting that meets their needs, an individualized re-assessment should determine the appropriate level of care for youth who are pregnant or parenting and evaluate whether the youth's needs can continue to be met in a family setting.*

Examples: *Because disclosure of trauma often occurs gradually, organizations can consider integrating routine trauma screenings into the ongoing assessment process, and including multiple reporters, to develop a more complete understanding of the child or family's trauma history.*

Family Foster Care and Kinship Care

FKC 5: Service Planning

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

The organization partners with children, parents, and resource families to develop service plans that are the basis for delivery of appropriate services and support.
Interpretation: *When the organization receives a service plan from another provider this service plan should contain all components identified within the standards.*

Interpretation: *When the case involves an American Indian or Alaska Native child and family, the organization must:*

1. *give tribal or local American Indian or Alaska Native representatives an active role in all aspects of service planning, service monitoring, and service delivery, including assessment, permanency planning, transition planning, case closing, and aftercare;*
2. *consider and prioritize culturally relevant resources available through or recommended by the tribe or local Indian organizations; and*
3. *provide timely notification of case reviews to tribal representatives to ensure their involvement, particularly when changes are made to the plan.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- In a few instances, client or staff signatures are missing and/or not dated; or
- With few exceptions, staff work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc.; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- In several instances, client or staff signatures are missing and/or not dated; or
- Quarterly reviews are not being done consistently; or
- Level of care for some clients is clearly inappropriate; or
- Service planning is often done without full client participation; or
- Appropriate family involvement is not documented; or
- Documentation is routinely incomplete and/or missing; or
- Individual staff members work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc., but this is the exception.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

* • Service planning procedures	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Parents
    4. Children and youth
    5. Resource parents
- Review case records

FKC 5.01

An assessment-based service plan is developed in a timely manner with the full participation of a supportive family team including the children, family, and resource family members, and addresses:

a. agreed upon goals, including permanancy goals, and desired outcomes;
b. strategies to address needs and challenges;
c. maintaining and strengthening family relationships and other informal social networks;
d. opportunities for children and families to choose a family team of supportive people to participate in service planning;
e. services and supports to be provided, by whom, and by when;
f. timeframes for accomplishing tasks and goals, evaluating progress, and updating plans;
g. the legal mandates for ensuring children's safety, permanency, and well-being;
h. procedures for expedited service planning when crisis or urgent need is identified; and
i. the signatures of parents, children, and family teams, whenever possible.

Interpretation: *Procedures for involving family members should be tailored to the specific circumstances of children and families, including:*

1. *prioritizing input of the child, and child welfare and law enforcement systems, to determine appropriate level of family involvement in cases where the child is a victim of human trafficking and family members may be complicit in trafficking;*
2. *developing procedures to promote safe and healthy participation of family members or making a determinination that meetings involving both the perpetrator and victim/survivor would pose a safety risk or be otherwise inappropriate, in cases involving domestic violence; and*
3. *demonstrating children's full participation in the development of their service plan when children have no family involvement.*

Interpretation: *When applicable, service plans should address strategies for working on challenging behaviors, including their antecedents, coping strategies, and contributing factors. For some organizations, this may include physical interventions which should not include:*

1. *mechanical restraints;*
2. *the use of drugs as a restraint or off label;*
3. *the seclusion of a child or youth in a locked room;*
4. *corporal punishment;*
5. *methods that interfere with the child or youth's right to humane care (e.g. deprivation of sleep or food); or*
6. *physical restraint holds except for a child who is at imminent risk of harm to themselves or others, if already outlined as permissible in the organization's policy and the service plan.*

Interpretation: *When the child or youth is a victim of human trafficking, the organization should work with the victim to develop a safety plan that focuses on increasing physical safety by securing needed documents, property, and services; maintaining the youth's location in confidence; and linking efficiently to law enforcement, if needed.*

FKC 5.02

Workers and supervisors, or clinical, service, or peer teams, review cases quarterly, or more frequently as determined by case status, to assess:

a. service plan implementation;
b. progress toward goals, including permanency goals;
c. the continuing appropriateness of goals, including permanency goals;
d. compliance with the Indian Child Welfare Act, as applicable; and
e. family time plans, as applicable.

Interpretation: *When experienced workers are conducting reviews of their own cases, the worker's supervisor must review a sample of the worker's evaluations as per the requirements of the standard.*

FKC 5.03

Workers and families, and supportive individuals when appropriate:

a. regularly review and document progress toward the achievement of goals, including family members' perspectives on progress and concerns regarding the case; and
b. sign revisions to service goals and plans.

Family Foster Care and Kinship Care

FKC 6: Child Permanency

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

The organization participates in or facilitates permanency planning to promote physical, emotional, and legal permanence for children.
Interpretation: *When the organization is not responsible for facilitating permanency planning, it documents all participation in the process and any efforts to connect children to positive relationships with significant adults.*

In addition, organizations demonstrate their role in supporting timely permanency planning through regular case record documentation and official reports provided to the local child welfare agency or the court which comment on children's and/or families' progress towards permanency goals.

Interpretation: *The permanency planning process for American Indian and Alaska Native children and families must always involve tribal representatives and service providers to ensure compliance with the Indian Child Welfare Act's placement preferences and support culturally responsive planning that recognizes and incorporates tribal definitions of permanency and tribal perspectives of the best interests of the child into the permanency plan. To facilitate full participation, the organization must ensure that the tribe or local Indian organization receives timely notification of court or administrative case reviews and is informed of any changes made to the permanency plan.*

Note: *Permanency planning often occurs in conjunction with service planning.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Procedures for permanency planning	

Site Visit Evidence

*
- Reports or other aggregate data regarding the length of stay in foster care for the organization, from the previous 12 months

On-Site Activities

*
- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Parents
    4. Resource parents
    5. Children and youth

- Review case records

FKC 6.01

Permanency planning:

a. occurs with families and the team of people that support them, including resource families, service providers, and extended family members or other supportive individuals identified by the family, as appropriate;
b. is scheduled at times when appropriate parties can attend; and
c. is child-driven, with children actively involved in every stage of the process as appropriate to their age and developmental level.

Examples: *Child-driven permanency planning can include, but is not limited to, involving children in:*

1. *conversations about what permanency means to them;*
2. *the discovery of extended family and other significant adults; and*
3. *the formation of a permanency team that will support their desired outcomes and have an ongoing role in their lives.*

FKC 6.02

The organization collaborates with children, parents, and the local child welfare agency to identify, notify, and engage kin who can be resources or supports for children of all ages, regardless of whether or not they currently wish to be adopted.

FKC 6.03

Concurrent planning is documented and includes:

a. early, preliminary, and reasoned assessment of the potential for reunification, the best interests of the child, and the need for an alternative plan;
b. full disclosure to all involved parties of all permanency options, including expectations, implications, available supports, and legal timelines;
c. joining a resource family that is prepared to develop a lifelong relationship with the child; and
d. counseling parents about relinquishment and alternative permanency options if needed.

FKC 6.04

Permanency plans document:

a. permanency goals;
b. why goals are in the best interest of children and their well-being;
c. why other permanency options are not appropriate; and
d. how service plans and identified interventions support permanency and child well-being.

FKC 6.05

Case records document efforts made to support parents towards reunification, including:

a. involvement in assessment, service planning, and service selection;
b. diligent efforts to provide parents with needed services and supports, including both formal and informal community resources;
c. ongoing, constructive, and progressive contact with their children; and

d. reduction of barriers to contact and involvement in their children's care.

NA: The organization, by virtue of law or contract, does not provide services to parents.

Interpretation: *When the organization is working with American Indian and Alaska Native children and families, the Indian Child Welfare Act requires active efforts be provided to support reunification. Active efforts require affirmative, thorough, timely, and culturally responsive engagement with families to satisfy the case plan by accessing resources and services and partnering with the tribe. Early consultation with the child's tribe is critical to ensuring that a full range of resources have been made available to the family and that active effort requirements are fulfilled. Organizations may work with tribal leadership, elders, religious figures, or professionals with expertise concerning the given tribe to determine culturally-responsive active efforts and identify culturally appropriate services for the family.*

FKC 6.06

To support permanency goals resource families are informed about, and assisted in, pursuing permanency options such as adoption or guardianship, as appropriate.

Examples: *Resource families, especially kinship caregivers, may require assistance overcoming barriers to pursuing permanency options, including negotiating boundaries with birth parents, navigating altered relationships within the family, and managing costs of care for children with significant medical or behavioral health needs.*

Family Foster Care and Kinship Care

FKC 7: Child Placement

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Children are placed with resource families who can best meet their needs for safety, permanency, and well-being, and best support their ties to family and community.
NA: The organization has no role in facilitating child placement.

Interpretation: *When placements are made by the court or another provider, the organization should collaborate with the court or placing agency to advocate for appropriate placement and promote placement stability, as emphasized throughout this core concept. An organization that provides emergency placements must document efforts made to meet the standards given the emergency nature of the placement.*

Note: *Foster Care to Adoption programs will implement FKC 7 and AS 9.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Placement procedures including: 1. matching children and resource families 2. preventing and managing placement disruptions	
*	• Procedures for reviewing placements and supporting placement changes	
*	• Procedures for finding and engaging kin	

• Policy regarding placement preferences	

Site Visit Evidence

• Aggregate report of resource family data for the previous 12 months (e.g. Resource Family Data Sheet)

On-Site Activities

• Interviews may include: 1. Program director 2. Relevant personnel 3. Resource parents 4. Parents 5. Children and youth • Review case records • Review resource parent records

FKC 7.01 (FP)

Resource family homes are licensed, approved, or certified according to state, tribal, or local regulation and the number of children in the home does not exceed five children total and also does not contain more than:

a. two children under the age of two;
b. four children over the age of 13; and
c. two children in treatment foster care.

Interpretation: *The total number of children includes all children under the age of 18 residing with the family, and includes any children residing with the family for overnight respite care. Exceptions to the maximum capacity may be made on a case-by-case basis to keep siblings together, to place children with relatives, to keep parenting youth together with their children, for other extenuating reasons that directly support plans for children to be connected to relationships that are safe, nurturing, and intended to be enduring, or when the home is licensed, approved, or certified by the state or tribe to care for more children and demonstrates through the family assessment and home study that the needs of every child can be met. Since these exceptions apply to kinship caregivers, maximum capacity limits established in this standard are not applicable when children are placed with kin.*

Interpretation: *When resource family homes are routinely licensed, approved, or certified according to state, tribal, or local regulations to contain a total of six children in the home they may receive a rating of 2 when they can demonstrate they are meeting the needs of every child in the home. This can be demonstrated by a combination of factors, such as:*

1. *strong performance on safety, permanency, and well-being outcomes, for instance, low placement change rates;*
2. *strong performance in resource family satisfaction and retention;*
3. *manageable caseload sizes for workers;.*
4. *ensuring space sufficient to maintain a safe and homelike environment;*
5. *increasing the number and frequency of visits by the worker to the home;*
6. *offering additional respite or child care opportunities to resource families; and*
7. *maintaining a lower capacity in homes where foster children and other dependents have higher needs.*

FKC 7.02

The organization identifies the best placement for each child using all available information regarding children's and resource families' strengths, needs, supports, and resources, including:

a. information obtained during initial and comprehensive assessments of children and families;
b. information obtained through the kin identification, notification, and engagement process, as applicable;
c. information obtained during assessments and annual reviews of resource parents;
d. information obtained during ongoing assessments and case reviews; and

e. the needs of any children already residing with the resource family.

Interpretation: *Needs to consider should include but are not limited to: language, any risk of harm to self or others, number of previous placements, history of running away and other behaviors, and any history of human trafficking, exploitation, or sexual abuse. The organization should also consider factors that would impact the resource family's ability to collaborate with the birth family, including language, geographic proximity, and cultural background.*

Interpretation: *Before placing additional children with resource families who are already providing treatment foster care, the organization should prioritize the needs of the child already in the home and consult with the resource family and members of the child's treatment team to assess and prepare for the impact of another child joining the family. Logistical as well as clinical factors should be considered, such as the frequency and location of specialized services.*

Examples: *Factors to consider when placing children with acute medical conditions or disabilities may include the accessibility of the resource family's home, such as the ability to accommodate mobility aids or medical devices, and any necessary modifications.*

FKC 7.03 (FP)

To ensure children are in the most family-like and familiar setting possible, the organization makes reasonable efforts to ensure children are placed:

a. with siblings;
b. with kin; and
c. with families that reside within reasonable proximity to their family and home community.

NA: The organization provides kinship care services only.

Interpretation: *Policy must require that preference be given to kin and deviations from these placement preferences must be documented in the case record with justifications and plans for ongoing contact with siblings or kin.*

FKC 7.04

The organization engages in a thorough kin-finding process when a child or youth first enters care and consistently throughout the duration of the case, which includes:

a. engaging children and family members in the process;
b. providing notification in family members' preferred languages;
c. providing notifications in multiple formats, including in writing, and
d. using clear, plain language to communicate the organization's goals and expectations regarding the kin's involvement.

Interpretation: *When identifying individuals related to the child by blood, marriage, or adoption, intensive efforts should be made to identify and notify at least relatives up to the third degree, and ideally relatives up to the fifth degree.*

Examples: *Methods for engaging in kin-finding can include, but are not limited to, Family Group Conferencing, interviews with children and family members, thorough reviews of the case record, and using technology resources including searches of social media.*

FKC 7.05

American Indian and Alaska Native children are placed according to the placement preferences specified in the Indian Child Welfare Act (ICWA).

NA:

- The organization provides kinship care services only.
- The organization provides services for foreign-born children only.

Interpretation: *When the organization is working with American Indian and Alaska Native children and families, tribal representatives and service providers must be involved in placement decisions and moves to ensure compliance with ICWA, which requires that preference be given to placements in the following order:*

1. *a member of the child's extended family;*
2. *resource families licensed, approved, certified, or selected by the child's tribe;*
3. *American Indian or Alaska Native families licensed, approved, or certified by a non-Native licensing authority; and*
4. *an institution approved by an Indian tribe or operated by an Indian organization.*

Alternative placement preferences established by the child's tribe may apply, and the court may also take into consideration the preferences of the child or their birth parents. Organizations should work closely with the child's tribe to identify placement options within the tribal community. Families from all tribes to which the child has ties should be considered as placement options, and eligibility criteria should be consistent with the norms of the tribe.

Emergency placements involving an American Indian or Alaska Native child must comply with the emergency proceeding provisions set out in ICWA. Efforts should be made to identify emergency placements that comply with the placement preferences in ICWA to prevent future placement changes if a full child custody proceeding is initiated.

FKC 7.06

The organization promotes the stability of children's living environments and prevents the need for placement changes through coordinated placement planning that:

a. ensures children, families, and resource families understand the steps involved in the process for a child joining a new family setting and receive support and information throughout;
b. provides all legally permissible information about each child's characteristics, behaviors, histories, physical and behavioral health needs, and permanency goals to prospective resource families;
c. ensures that resource families make an informed decision to accept children into their care;
d. arranges opportunities for children and parents to meet prospective resource families when possible;
e. responds proactively to challenges that arise by assessing needs and arranging necessary services, supports, or interventions to preserve the placement when in the best interests of the child;
f. permits children transitioning from treatment foster care to remain in their living environment whenever possible and appropriate; and
g. facilitates workers' ability to spend more time with children, families, and/or resource parents after children first come into the home or when challenges arise.

Interpretation: *Regarding element (b), information related to children's behaviors and behavioral health needs should be prepared or delivered by qualified personnel who can provide a clinical and developmental perspective, including information about the child's previous living environments and trauma history, and their relevance to the child's current and previous behaviors and functioning. This may also include consulting the child, when appropriate, about the appropriate level of detail to be shared with prospective resource families concerning the child's traumatic experiences.*

FKC 7.07

The appropriateness of children's placements is reviewed regularly, and changes occur to support children's best interests and permanency goals, as needed.
Interpretation: *In treatment foster care, when placements are reviewed in connection to changes to the child's assessed level of care, placement decisions should be based on the child's treatment progress and present needs rather than length of stay, and organizations should explore strategies for maintaining placement stability when indicated.*

Examples: *Placement changes that support children's best interests and permanency goals may include moving from a foster family to an adoptive family, moving from a non-kin resource family to a kinship resource family, or other changes that bring children closer to family or community.*

FKC 7.08

Children, families, and resource families receive additional support during placement changes that includes:

a. sufficient advanced notice provided at least 14 days prior to a placement change, when possible;
b. formalized discussions of the reasons for a move or disruption, each party's feelings about the change, and as needed, interventions to address the reasons for the change;
c. identification of a resource family or other placement setting that can best promote safety, well-being, and permanency;
d. providing opportunities for children and resource families to meet with the new resource family and/or visit the new placement setting, when possible; and
e. referral to additional services or supports.

Family Foster Care and Kinship Care

FKC 8: Developing and Maintaining Connections

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

The organization promotes the development of social and emotional well-being and positive support systems for all children by facilitating connections with family, peers, and community.

NA: The organization does not provide case management services for children.

Interpretation: *If the organization does not facilitate or supervise in-person contact it should maintain documentation of all in-person contact between children and families, children's response to contact with family, and all efforts to support other forms of contact between children and their families and networks of support.*

Note: *COA uses the term "family time" rather than "visitation" to emphasize that children belong with their families, and highlight the importance of the time families spend together when children are in out-of-home care.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Policy prohibiting restriction of in-person contact as a disciplinary action	
*	• Procedures for ensuring ongoing, meaningful contact	
*	• Procedures for family time planning and implementation	

*	• Family time plan template or sample

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
  1. Program director
  2. Relevant personnel
  3. Resource families
  4. Parents
  5. Children and youth
- Review case records

FKC 8.01 (FP)

Unless contraindicated, planned, ongoing contact between children, parents, and siblings occurs as frequently as possible based on children's ages and developmental needs, and at a minimum in-person contact occurs:

a. weekly between children and parents; and
b. monthly between siblings.

NA: By virtue of law or contract, the organization does not develop or facilitate the implementation of family time plans.

Interpretation: *Children and parents are entitled to in-person contact unless parental rights are terminated and in some cases after termination, and incarcerated or detained parents are entitled to in-person contact unless restricted. Contact with siblings and parents should take place concurrently whenever possible and appropriate.*

In addition to in-person contact children can maintain contact in other ways, such as through web-based technologies and other electronic communications.

Examples: *Very young children, in particular, benefit from in-person contact as frequently as possible in order to develop and maintain strong attachments with their parental figures and promote developmental progress. Infants may need daily contact and toddlers may need contact at least every two to three days.*

FKC 8.02

The organization offers a continuum of family time options, and written family time plans are:

a. developed in collaboration with parents, resource parents, and children;
b. informed by assessment information;
c. focused on relationship-building;
d. determined by permanency goals modified in accordance with permanency planning; and
e. in compliance with all court orders.

NA: By virtue of law or contract, the organization does not develop or facilitate the implementation of family time plans.

Interpretation: *The organization should encourage unsupervised contact in normative community settings when possible and appropriate, and should only require supervised family time (i.e. supervised visitation) when assessments indicate safety concerns or the need for coached family time.*

Interpretation: *When the organization is working with American Indian or Alaska Native children and families, representatives from their tribes or local Indian organizations should be included in the development of the family time plan.*

Interpretation: *For organizations that operate an Unaccompanied Refugee Minor Foster Care Program, family time plans may exist for contact with siblings and are typically developed by the Office of Refugee Resettlement and applicable judicial bodies.*

FKC 8.03

Written family time plans include:

a. start dates, frequency, time, length, and location of in-person contacts;
b. participants;
c. transportation arrangements;
d. supervision or monitoring requirements, if any;
e. developmentally-appropriate and interactive activities;
f. opportunities to practice caregiving skills and activities;
g. cancellation arrangements; and
h. preparation and debriefing arrangements.

NA: By virtue of law or contract, the organization does not develop or facilitate the implementation of family time plans.

Examples: *Plans may involve appropriate extended family and friends to support regular contact and maintain families' support systems. For example, these supports might provide transport, offer their homes for parents and children to spend time together, involve children in cultural or community events, or provide respite for resource parents.*

Examples: *When children are in treatment foster care, family time can be an opportunity for birth parents and treatment parents to discuss the child's condition(s) and collaboratively develop strategies for managing the child's needs after reunification or while in out-of-home care.*

FKC 8.04

Workers or designees promote meaningful and constructive contact by:

a. helping children, parents, and resource families prepare for and transition to and from in-person contact;
b. following-up with children, parents, and resource families after in-person contact to process the experience, ascertain progress, and assess for concerns that may indicate the need to modify plans or services; and
c. documenting the activities that occurred and behaviorally-specific observations that pertain to family relationships and parenting to be considered in assessing case progress.

Examples: *Workers can help children, parents, and resource families prepare for and transition to and from in-person contact by, for example:*

1. *helping parents and children prepare for relationship-building activities related to service or family time plans;*
2. *helping resource parents understand issues surrounding family time and their role in supporting both the child and the family time process; and*
3. *helping all parties understand that negative responses to family time in either parents or children can be a normal response to separate-related trauma rather than an indication that the family time plan or services should be changed.*

FKC 8.05 (FP)

Organization policy prohibits cancellation or restriction of in-person contact as a disciplinary action for either parents or children.

FKC 8.06

Children are assisted to develop social support networks by identifying, building, and sustaining relationships with caring individuals of their choosing, including:

a. extended family;
b. peers;
c. former resource families;
d. other individuals with whom they had a prior relationship; and
e. members of their community, ethnic group, faith group, clan, or tribe.

Interpretation: *In situations with known or suspected concerns about human trafficking, organizations should be aware that traffickers may pose as a boyfriend or older relative, or communicate through another individual and utilize in-person contact to continue the exploitation of the victim.*

Family Foster Care and Kinship Care

FKC 9: Services for Parents

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Parents receive individualized services and supports that address their needs, increase their capacities for effective parenting, and assist them in preparing for reunification or facilitating other permanency options for their children.
NA: The organization, by virtue of law or contract, does not serve parents, or the organization only serves children who are legally free for adoption.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Procedures for promoting collaboration between parents and resource families	
*	• Procedures for referring parents to core services	

Site Visit Evidence

*	• Contracts or service agreements with community providers for the provision of services to parents • Informational materials provided to parents • Community resource and referral list

On-Site Activities

*
- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Parents
    4. Resource parents

- Review case records

FKC 9.01 (FP)

The organization minimizes the negative effects of separation and promotes families' commitment to services by:

a. explaining the rights and responsibilities of resource families;
b. providing clear, transparent, and comprehensible information that enables family members, according to their abilities, to understand the organization's role, processes, concerns, and expectations, including potential ramifications of not participating in services;
c. explaining how service plans will be implemented to ensure involvement and contact with their children, and communication with the organization and the resource family;
d. valuing family members' input and perspectives regarding their experiences, strengths, risks, and needs; and
e. offering choices that respect the role of parents in the lives of their children and help family members retain a sense of control.

Interpretation: *The organization should assume the presence of trauma, and adopt a trauma-sensitive approach to engagement. Workers should: be aware that involvement with the child welfare system can be a trauma reminder; recognize that challenging behaviors such as anger, apathy, or non-compliance may actually be a defensive or protective reaction to the involvement of the child welfare system; and ensure that interactions with parents are sensitive and responsive to any history of trauma.*

FKC 9.02

Parents are connected to culturally-relevant services directly or through referral, that help them meet their needs and reunify and stabilize their families, including:

a. child care;
b. housing referral and assistance;
c. public benefits and income support, including any assistance needed to obtain food, clothing, and utility services;
d. immigration services;
e. home care and support services, including household management and home health aide services;
f. medical and dental care;
g. respite care;
h. transportation services; and
i. vocational and educational assistance.

FKC 9.03 (FP)

Families receive intensive services, as needed, from domestic violence, mental health, and substance use treatment specialists.

FKC 9.04

Service interventions are designed to help parents:

a. evaluate the impact of their past experiences on current functioning and parenting practices;
b. target situations that pose challenges for the family;
c. develop and strengthen the skills they need to manage challenging situations;
d. strengthen and repair parent-child relationships, as needed; and
e. access trauma-informed services.

Interpretation: *Parents involved with the child welfare system due to family conflict or rejection related to their child's sexual orientation or gender identity should be connected to counseling and educational resources that will help them to develop the knowledge and skills needed to manage the conflict, accept and support the child, understand and meet the needs of their child, and rebuild the parent-child relationship.*

Examples: *Interventions may target skills and strategies needed to:*

1. *express and regulate emotions;*
2. *control impulses;*

3. *cope with stress and adversity;*
4. *communicate effectively;*
5. *make decisions;*
6. *resolve conflicts and solve problems;*
7. *identify, seek, and access needed services and supports;*
8. *identify, anticipate, and manage their responses to trauma reminders;*
9. *increase awareness and mindfulness;*
10. *engage in effective self-care; and*
11. *manage a home and budget.*

Examples: *The Solution Based Casework model emphasizes the importance of helping families build the skills they need to handle the everyday tasks that result in threats to safety and well-being, from supervising young children, to keeping the home clean and safe, to controlling anger or substance use. Caseworkers partner with parents to identify the situations that pose challenges for the family, develop specific plans of action for dealing with those challenges in ways that reduce risk and promote safety, and celebrate the behavioral changes that occur.*

FKC 9.05

Parent education and support services promote development of the knowledge and skills needed to:

a. understand the physical, cognitive, social, and emotional development of children, as well as factors and conditions that can promote or impede healthy development;
b. provide nurturing care that promotes secure attachment and healthy development;
c. provide appropriate supervision and monitoring;
d. develop appropriate expectations regarding, and techniques for managing, children's behavior;
e. maintain a safe home environment; and
f. meet any special needs that children may present, including needs related to medical conditions or mental health diagnoses.

Examples: *Constructive family time can provide an important opportunity for practicing newly learned skills and improving parenting abilities.*

FKC 9.06

In an effort to build strong and healthy family support networks, parents are helped to:

a. identify current sources of support;
b. develop plans for managing any negative influences in their networks; and
c. explore how they might expand their social support networks, if necessary.

Examples: *Extended family, friends, neighbors, co-workers, and other community members may help to provide the ongoing support a family will need over time. Efforts to help parents strengthen their support networks may overlap with efforts undertaken during assessment or service planning to develop a family "team".*

FKC 9.07

Resource families maintain connections with parents to mutually share information about their children and support parents' involvement in their children's care, unless contraindicated.
Interpretation: *It is particularly important that resource families maintain regular communication with the parents of infants and toddlers, who may be unable to express their needs, in order to best meet the needs and keep the parents abreast of changes during this period of rapid child development.*

Interpretation: *In treatment foster care, regular communication should also address the child's treatment progress, including services received, responses to current interventions, behaviors, new information about trauma history, identified triggers, and upcoming appointments.*

Examples: *Regular communication may address the child's educational progress, social connections, health concerns and medical care received, interests, preferences, and special events.*

Family Foster Care and Kinship Care

FKC 10: Services for Children and Youth

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Children and youth receive developmentally-appropriate support and services that promote well-being.
NA: The organization does not provide case management services for children.

Interpretation: *Informal Kinship Care Programs should work closely with kinship caregivers to meet the needs identified in the standards through support and mentoring, advocacy, direct referrals for service, and linkages to community resources.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
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- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

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- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

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- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Procedures for referring children to services	
*	• Procedures for educational collaboration and support	

Site Visit Evidence

*	• Informational materials provided to children • Community resource and referral list • Contracts or service agreements with community providers for the provision of services to children and youth

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Resource parents
    4. Children and youth

- Review case records
- Visit resource family homes

FKC 10.01 (FP)

Children receive a developmentally-appropriate orientation to the program and the resource family that addresses:

a. their rights and responsibilities when they are not living with their parents or primary caregivers;
b. what they need to feel safe, what to do and who to contact when they feel unsafe or their rights are violated, and the risks and alternatives to running away;
c. the rules in the program and in the resource family's home and their response to the rules; and
d. their ongoing contact with their parents, siblings, extended family, friends, and community.

FKC 10.02 (FP)

Children reside in safe and supportive homes that provide:

a. a safe, pleasant, and welcoming atmosphere;
b. nurturing and nonjudgmental family relationships that promote positive attachment and support emotional development and well-being;
c. age- and developmentally-appropriate boundaries, supervision, and discipline;
d. an orderly but flexible daily schedule that is balanced with attention to development and well-being; and
e. space in their room to personalize.

FKC 10.03 (FP)

In order to ensure that their personal care needs are met, children are provided with:

a. a physical environment and materials that support healthy development;
b. sufficient and nutritious meals and snacks;
c. clothing that supports their self-expression and is clean, seasonal, age appropriate, and comfortable;
d. an allowance for personal needs, as appropriate, including access to appropriate and individualized grooming and hygiene products;
e. assistance in meeting personal care needs, as appropriate; and
f. regular access to a telephone to contact workers, advocates, service providers, and approved family and friends.

FKC 10.04

Children have opportunities to participate in a range of age and developmentally appropriate social, recreational, cultural, educational, religious, and community activities of their choice.
Interpretation: *Participation in activities should be incorporated into the child's service plan and/or treatment plan, and should not be leveraged as a disciplinary measure. Children in out-of-home care should be encouraged to participate in the same range of normal activities and life experiences as children living with their families of origin, and have the right to choose whether or not they wish to participate in a resource family's religious activities.*

Examples: *Participating in "normal" activities activities can help children and youth form healthy relationships, develop interests, build skills and resilience, promote positive physical and mental health, and prepare for responsible adulthood, and may include:*

1. *joining a club or sports team;*
2. *attending a dance class;*
3. *spending time with friends;*
4. *having a sleepover;*
5. *attending field trips;*
6. *volunteering;*
7. *dating;*
8. *learning to drive; and*
9. *holding a part-time job.*

FKC 10.05

In an effort to facilitate normalcy and help resource parents make appropriate decisions regarding the children in their care, the organization clarifies:

a. resource parents' authority to make day-to-day decisions regarding children's participation in activities, including the specific types of activities they are permitted to authorize;
b. factors to consider in determining whether an activity is safe and appropriate for a particular child; and
c. the extent to which resource parents are protected from liability if a child is harmed during the course of an activity they approved.

Interpretation: *In determining whether a child should be allowed to participate in a particular activity the resource parent should consider: (1) the child's age, developmental level, maturity, and behavioral history; (2) potential risk factors associated with the activity; (3) the best interest of the child, including potential for emotional and developmental growth; and (4) whether the resource parent would permit his or her own children to participate in the activity in question.*

In treatment foster care, treatment parents may consult the treatment team to identify additional factors to consider, regularly review the types of activities and level of independence that should be encouraged or limited based on treatment progress, and address promoting the child's development of abilities necessary for safe participation in a chosen activity.

When regulation or contract requires the organization to obtain approval from the public authority prior to a resource parent approving an activity, the organization should work with the resource parents and the public authority to ensure that requests are approved efficiently and promote normalcy to the greatest extent possible.

FKC 10.06

Children receive any additional services and supports needed to help them:

a. regulate their emotions and behavior;
b. communicate effectively;
c. form positive relationships with adults and peers; and
d. explore and develop their personal, social, and cultural identities.

Examples: *Sources of support may include, but not are limited to: workers, resource families, family members, peers, and community members and organizations. Services can include but are not limited to: counseling or group therapy, formal opportunities for social skills development, and mentoring services.*

FKC 10.07

Children receive support to achieve their full educational potential through:

a. enrollment and participation in school and other educational programs;
b. services and supports that promote positive development;
c. regular and ongoing communication and collaboration between workers, educators, resource families, and parents regarding children's educational achievements and challenges, as well as any social or behavioral issues in the school setting;
d. stability in their home schools, unless it is determined not to be in their best interest;
e. educational assessments and an individual education plan when needed;
f. tutoring; and
g. advocacy.

Interpretation: *Educational advocacy, communications, and collaboration should include:*

1. *identifying trauma triggers and effective behavior support techniques and resources in the school setting;*
2. *consistent communication with teachers, administrators, counselors, and other school support personnel about court dates, family time plans, medical appointments, and other external factors that may impact the child's attendance, behavior, or academic performance; and*
3. *negotiating flexibility around school policies that create barriers to academic and placement stability, such as exclusionary disciplinary actions or zero tolerance policies towards previous behavior.*

Examples: *Depending on age and developmental level, appropriate education supports and services may include:*

1. *early childhood education programs;*
2. *early intervention services;*
3. *special education programs;*
4. *accredited primary and secondary schools; and*
5. *after-school or youth development programs.*

FKC 10.08

Children are treated in a trauma-informed manner and when needed are connected to trauma-informed services that are designed to:

a. maximize their sense of safety;
b. help them understand and process their traumatic experiences;
c. facilitate the development of skills and strategies to use when confronted with reminders of trauma;
d. help create and sustain positive attachments with caring adults and peers; and
e. help caregivers and parents understand how children's past experiences may impact their present behavior, and appropriately support children's recovery.

FKC 10.09

In an age- and developmentally-appropriate manner, the organization works with children, parents, and resource families to promote children's self-sufficiency and informed decision-making related to:

a. activities of daily living;
b. practicing effective interpersonal communication and conflict resolution;
c. promoting and managing health;
d. obtaining housing and managing their households;
e. accessing educational opportunities;
f. obtaining and maintaining employment;
g. money management, including budgeting, saving, investing, buying on credit, and debt counseling;
h. accessing community resources; and
i. navigating public assistance and other governmental programs.

Interpretation: *The standard is applicable for all children regardless of age. FKC 15 provides further detail as to the services and supports provided to youth as they move towards the transition to adulthood.*

Family Foster Care and Kinship Care

FKC 11: Physical and Mental Healthcare

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Children receive comprehensive healthcare services within appropriate timeframes to promote optimal physical, emotional, and developmental health.
NA: The organization does not provide case management services for children.

Interpretation: *When possible, American Indian and Alaska Native children should receive services from qualified professionals who have experience working with the tribe and knowledge of tribal customs and practices. Organizations that have the responsibility for placing American Indian and Alaska Native children should be aware of services that the child may have access to through tribally contracted health facilities or through the federal Indian Health Services. The organization should work with the tribe or a local Indian organization to ensure they have access to needed medical information.*

Examples: *Providing children with a medical or health home, where care is provided by professionals with expertise on the issues of children in out-of-home care, can help to ensure that they receive comprehensive services that meet their needs.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Initial health screening procedures	
*	• Procedures for the coordination and provision of physical and mental health care assessments and services	

Site Visit Evidence

*
- List of health and mental care providers, with credentials
- Informational health and wellness materials provided to children and youth

On-Site Activities

*
- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Resource parents
    4. Parents served
    5. Children and youth

- Review case records

FKC 11.01 (FP)

Prior to or within 72 hours of initial entry into the child welfare system children receive an initial health screening from a qualified medical practitioner to:

a. identify health conditions that require immediate or prompt medical attention;
b. identify health conditions that should be considered in making placement decisions; and
c. determine the need for developmental assessment for children under six.

Interpretation: *The initial health screening for children entering the foster care system, as recommended by the American Academy of Pediatrics, should only be conducted by a qualified medical practitioner. When possible, the screening should be performed by the child's primary care physician who knows the child's medical history, or a physician that can serve as the child's medical home while in foster care. The screening may be completed by a nurse practitioner, registered nurse, or physician's assistant if a physician is unavailable.*

1. *For a rating of 2, appropriately qualified and trained professional staff can administer a brief screening tool to determine if more immediate medical care is needed. The organization must demonstrate that: the screening tool was developed in collaboration with a qualified medical practitioner;*
2. *the tool and its administration are appropriately designed to be within the scope of the staff's qualifications;*
3. *staff are trained on the administration of the tool and related procedures; and*
4. *procedures outline criteria for determining the need for and accessing medical care.*

Interpretation: *When the local child welfare authority is responsible for ensuring that the initial health screening occurs, the foster care organization must maintain documentation of the screening to ensure response to all conditions that affect placement decisions and conditions that require follow-up. The screening may be in the assessment that occurs when a child is taken into custody following treatment at a hospital, clinic, or medical office.*

Interpretation: *Organizations should develop their own procedures, consistent with state, tribal, or local regulation, regarding whether it is appropriate for children in the temporary legal custody of kin to receive an initial health screening.*

Examples: *Conditions that require immediate or prompt medical attention include, but are not limited to: acute illnesses, chronic diseases requiring therapy, signs of abuse or neglect, signs of infection or communicable diseases, hygiene or nutritional problems, pregnancy, and significant developmental or mental health disturbances.*

FKC 11.02

Relevant health information is shared with providers and resource parents, as available and/or appropriate, concerning the child's:

a. physical and mental health;
b. family history;
c. trauma history; and
d. prescribed medications, including their dosages, targeted symptoms, side effects, and monitoring processes for any psychotropic medications.

FKC 11.03 (FP)

Qualified professionals provide children with age-appropriate health services including:

a. comprehensive medical examinations within 30 days of entry into foster care and according to well-child guidelines;
b. dental examinations for children over age three within 30 days of entry into foster care and every 6 months thereafter, or more frequently based on clinical need;
c. developmental screenings within 30 days of entry into foster care to identify the need for further assessment for children over age six;
d. ongoing developmental screenings according to well-child guidelines to identify the need for further assessment,
e. alcohol and drug abuse screenings within 30 days of entry into care, and when indicated to identify the need for further diagnostic assessment; and
f. any services needed to address issues or conditions identified during health screenings, assessments, or examinations.

Interpretation: *Organizations should follow the Recommendations for Preventative Health Care for children in foster care published by the American Academy of Pediatrics. Medical assessments should include, as appropriate to children's ages and circumstances: lead exposure, tuberculosis testing, and HIV/STD risk assessment screening.*

Interpretation: *Regarding element (b), the organization can receive a rating of 2 if there is an annual preventive exam and evidence that recommendations from the dental care provider indicate children are not in need of more frequent care.*

FKC 11.04 (FP)

Children receive:

a. mental health screenings within 30 days of entry into the child welfare system, and when indicated thereafter; and
b. diagnostic mental health assessments, when indicated.

Interpretation: *Initial screenings can be conducted by trained caseworkers, but follow-up mental health assessments should be provided by qualified mental health professionals. Screenings should include attention to trauma exposure and symptoms, and trauma-focused assessments should be provided when needed. When a child is in treatment foster care the diagnostic mental health assessment must occur within 30 days prior or subsequent to placement.*

FKC 11.05 (FP)

Qualified mental health professionals provide:

a. any needed mental health services, including evidence-based psychosocial services and pharmacological treatments, as appropriate; and
b. appropriate oversight of psychotropic medication use, including close supervision and monitoring of children receiving multiple medications or medications for off-label uses.

FKC 11.06

Children receive age and developmentally appropriate support and education regarding:

a. proper nutrition and exercise;
b. substance use and smoking;
c. personal hygiene;
d. safe and healthy relationships;
e. sexual development;
f. family planning and pregnancy options;
g. pregnancy, prenatal care, and effective parenting;
h. prevention and treatment of sexually transmitted infections/diseases; and
i. HIV/AIDS prevention.

FKC 12: Supports and Services for Expectant and Parenting Youth

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

The organization promotes the safety, permanency, and well-being of children and youth who are expectant or parenting by providing, or assisting with access to, resources and supports that empower them to make informed decisions about pregnancy, experience healthy births, and develop the skills needed for personal functioning and parenthood.

Interpretation: *The needs of expectant and parenting children and youth can be met through a continuum of care that includes "whole family" placements, specialized foster care, residential treatment, and supportive living arrangements. The organization should aim to meet the needs of expectant and parenting youth and their children in the most family-like setting that best meets their needs. Given that youths' needs often go unmet, it is crucial that caseworkers provide close oversight and plan an active role in monitoring the receipt of services.*

Interpretation: *The term "expectant youth" refers to both expectant mothers and fathers. The term "parenting youth" refers to both custodial and non-custodial mothers and fathers. The term "pregnant youth" refers exclusively to birth mothers.*

Rating Indicators:

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- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
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- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
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Table of Evidence

Self Study Evidence

*	• Procedures for referring youth and their children to services	
*	• Policy regarding the parenting rights of youth	

* • Parenting skills assessment tool	
* • Table of contents for parenting education curricula	
* • Procedures for developing parenting plans	

Site Visit Evidence

* • Relevant portion of contract with public authority that limits services to pregnant youth, if applicable • Community resource and referral list • Contracts or service agreements with community providers for the provision of services to expectant and parenting youth • Informational materials provided to youth • Parenting education curricula

On-Site Activities

* • Interviews may include: 1. Program director 2. Relevant personnel 3. Youth served, and their children if appropriate 4. Resource parents • Review case records

FKC 12.01

Pregnant youth receive access to timely, ongoing, and relevant services appropriate to their needs that address:

a. pregnancy counseling;
b. prenatal health care;
c. diagnosis and treatment of health concerns, including sexually transmitted diseases;
d. genetic risk identification;
e. food and nutrition;
f. mental health care;
g. substance use conditions;
h. medication use;
i. smoking cessation; and
j. labor and delivery.

Interpretation: *Regarding element (h), a qualified mental health professional should re-evaluate pharmacological treatments for safety, risks, and benefits during pregnancy and make appropriate adjustments to the treatment plan, such as tapering or adjusting dosages or increasing monitoring of symptoms.*

Interpretation: *The organization supports the safety and well-being of pregnant youth by maintaining stable placements in family-like settings whenever possible. If placement transfer is contractually required when people become pregnant, the organization should assist with accessing prenatal education and care up until discharge.*

FKC 12.02

Following childbirth, the organization promotes child and maternal well-being, and prepares parenting youth to recognize and respond to signs of problems in both themselves and their infants by ensuring they receive timely postnatal care, education, and support related to:

a. postpartum health care;
b. postpartum depression, including screening for and addressing changes in the new mother's mood, emotional state, behavior, and coping strategies;
c. breastfeeding education and assistance; and
d. pediatric care, including well-baby visits and immunizations.

NA: The organization is required by contract to transfer pregnant youth out of their care prior to childbirth.

FKC 12.03

Youth who are expectant or parenting are informed of their legal rights to custody of their children and are maintained together with their children unless a safety risk is identified.
Interpretation: *Organization policy should clearly assert that youth should not be separated from their children solely due to the youth's age or involvement with the child welfare system, or as a means of obtaining services or financial support for the child.*

FKC 12.04

Expectant and parenting youth are helped to develop skills and knowledge related to:

a. basic caregiving routines;
b. child growth and development;
c. meeting children's social, emotional, and physical health needs;
d. environmental safety and injury prevention;
e. parent-child interactions and bonding;
f. age-appropriate behavioral expectations and appropriate discipline;
g. family planning; and
h. establishing a functioning support network of family members or caring adults.

FKC 12.05

Workers collaborate with youth who are expectant or parenting and their caregivers, co-parents, and other family members when appropriate, to develop individualized parenting plans that define:

a. the rights and responsibilities of the youth parents; and
b. each individual's role and expectations for supporting the youth parents to care for their children.

FKC 12.06

Workers assist youth who are parenting to obtain or enroll in assistance that will support them to care for their children and work towards financial independence, including:

a. public benefits such as Medicaid, WIC, SNAP, and TANF;
b. transportation;
c. maternal and child health programs;
d. legal advocacy;
e. affordable and quality child care;
f. community resources, such as free clinics; and
g. educational or vocational programs that support and accommodate the circumstances of expectant and parenting youth.

FKC 12.07

The organization promotes responsible fatherhood and paternal engagement by:

a. indicating in the case record when youth in care become fathers;
b. identifying the relationship between expectant youth parents;
c. linking young fathers to services that help them understand their legal rights and responsibilities, establish legal paternity, and adjust to the parenting role; and
d. assisting youth who are pregnant to notify birth fathers and engage them in service planning, when appropriate.

Family Foster Care and Kinship Care

FKC 13: Treatment Foster Care

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Children with significant emotional, behavioral, medical, or developmental needs receive structured treatment within a therapeutic family setting that promotes well-being, family connections, and community integration.
NA: The organization does not provide treatment foster care services.

Note: *Organizations providing Foster Care Home Services only will complete FKC 13.07-FKC 13.10 only.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Criteria for selection of treatment foster parents	
*	• Worker contact procedures	
*	• Table of contents of treatment model training for staff and treatment foster parents	
*	• Treatment planning and review procedures	
*	• Discharge procedures	

Site Visit Evidence

*

- Formal, written agreements between the organization and therapeutic facilities and/or providers that serve children and families in the program
- On-call schedule for treatment foster care programs for previous six months
- Documentation tracking treatment foster parent completion of required training
- Training curricula for treatment foster parents

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Parents
    3. Treatment team members
    4. Treatment foster parents
    5. Children and youth

- Review case records
- Review treatment foster parent records

FKC 13.01

Treatment foster services are delivered by individualized treatment teams that include:

a. family members;
b. treatment foster parents or kinship caregivers;
c. local child welfare agency workers;
d. treatment foster care program personnel, including the program supervisor, case managers, and clinicians or clinical consultants;
e. educators or school administrators; and
f. a range of specialized providers, as appropriate to children's emotional, behavioral, medical, and/or developmental needs.

NA: The organization provides Family Foster Care Home Services only.

Interpretation: *The treatment team should include at least one worker or contract employee, in addition to the supervisor, who has an advanced degree in social work or a related field and at least two years of professional experience working with children with specialized treatment needs.*

Examples: *Depending on the needs of children, specialized providers may include, but are not limited to: behavior support specialists; nurses; primary care and specialist physicians; psychiatric nurses and psychiatrists; and occupational, physical, and speech rehabilitation therapists.*

The team may also include the child's guardian ad litem or legal representative.

FKC 13.02

Preliminary treatment plans developed prior to placement identify:

a. diagnoses;
b. strategies to ensure children’s adjustment to treatment families; and
c. short-term goals for the first 30 days of out-of-home care.

NA: The organization provides Family Foster Care Home Services only.

FKC 13.03

Within 30 days of placement, treatment teams develop individualized, comprehensive treatment plans that:

a. identify, incorporate, and build on the child’s strengths and assets;

b. specify diagnoses and presenting problems that prompted the referral to treatment foster care or were identified during assessment;
c. address needs in major developmental areas;
d. specify short- and long-term therapeutic interventions;
e. review any psychotropic medication use, including dosages, side effects, and contraindications;
f. address stressors in the child's environment that are trauma reminders or contribute to their emotional or behavioral issues;
g. establish an emergency response plan for medical emergencies or behavioral health crises related to the child's condition; and
h. establish initial plans for respite care, discharge, and aftercare.

NA: The organization provides Family Foster Care Home Services only.

Interpretation: *When children are prescribed psychotropic medications, the treatment team must collaborate to ensure the treatment parent understands the specified medication's intended use, relevant precautions, protocols for monitoring efficacy and side effects, and what to do in the event of negative reaction or improper administration.*

FKC 13.04

Treatment plans are:

a. discussed weekly by the treatment team to coordinate an effective response to current issues or behaviors;
b. reviewed monthly to evaluate progress towards treatment goals; and
c. officially updated every 90 days to evaluate progress and the continued need for treatment foster care.

NA: The organization provides Family Foster Care Home Services only.

Interpretation: *Intervals for discussing treatment plans for medically fragile children should be established based on the intensity of the child's ongoing needs.*

When children transition to a lower intensity level of care, such as traditional foster care, but are able to remain in the care of the same resource family, treatment foster parents should be helped to prepare for any resulting changes in supports and services, including reduced worker contact or reimbursement rates.

Interpretation: *Treatment planning and review should also address the use of restrictive interventions, when authorized, including an evaluation of the frequency of use and effectiveness of prevention strategies.*

FKC 13.05

The organization coordinates and ensures the provision of needed therapeutic, rehabilitative, and support services, including specialized treatment services.
NA: The organization provides Family Foster Care Home Services only.

Examples: *Needed services may include, but are not limited to:*

1. *individual, family, and/or group therapy,*
2. *social skills groups, and*
3. *medical treatment.*

FKC 13.06 (FP)

Formal agreements are established between the organization and:

a. mental health facilities, medical institutions including neonatal and pediatric facilities, and other rehabilitation service providers to ensure the availability of requisite medical and mental health services; and
b. a board-certified physician with experience appropriate to the level and intensity of service, and the needs of the population served, who assumes responsibility for medical elements of the program when it serves children with acute medical needs.

NA: The organization provides Family Foster Care Home Services only.

Examples: *The board-certified physician can provide service as an employee, contractor, or through formal agreement.*

FKC 13.07 (FP)

The organization selects treatment parents based on established criteria that are determined based on the characteristics of children who need treatment foster care, and include:

a. an assessment of the family's capacity to provide therapeutic care for children with significant needs;
b. three non-relative references; and
c. attainment of at least 21 years of age.

Interpretation: *Regarding element (a), the selection process for treatment families must also meet the resource family assessment standards outlined in FKC 18.*

Examples: *Regarding element (a), demonstrated capacity may include previous experience as a resource parent or work experience in a therapeutic setting, such as a residential treatment center, or as a healthcare provider, if being selected to care for children with acute medical needs or physical disabilities.*

Organizations can foster recruitment of existing resource families to become treatment families by facilitating opportunities to connect with experienced treatment parents to learn about the treatment parent experience.

FKC 13.08

Treatment foster parents receive specialized pre-service treatment foster care training to prepare for their professional and parenting roles and to assume primary responsibility for:

a. implementing in-home treatment strategies;
b. assisting children to understand treatment goals and interventions;
c. documenting children's behaviors and progress in targeted areas and responses to services and interventions received; and
d. acting as liaisons with clinical personnel.

Interpretation: *Pre-service training should include learning opportunities that incorporate the experience of veteran treatment parents, such as peer mentoring, coaching, situational role-play, or other training activities that illustrate real life scenarios.*

Examples: *Treatment foster care programs can provide joint trainings for workers and treatment parents in certain areas, such as trauma informed care, to facilitate mutual learning, foster positive relationships between workers and treatment parents, and reinforce treatment parents' professional role.*

FKC 13.09

Treatment parents receive initial and ongoing training that addresses:

a. managing the needs and diagnoses specific to each child;
b. crisis prevention and de-escalation;
c. navigating the child welfare, behavioral health, and healthcare systems;
d. educational advocacy skills and the special education system;
e. incorporating other providers and medical equipment, as necessary, into the home; and
f. engaging with birth families, including when appropriate, discussing and/or demonstrating interventions, advocacy skills, and other competencies related to the child's conditions.

Interpretation: *Regarding element (a), the organization should provide treatment parents with enhanced training or other relevant learning opportunities when placing children with treatment parents who do not have experience with the child's specific needs or conditions.*

Depending on children's needs, enhanced training should address:

1. *adjusting parenting and communication styles to the child's emotional or developmental needs;*
2. *teaching basic life skills;*
3. *engagement strategies for youth;*
4. *verbal de-escalation techniques;*
5. *recognizing the child's triggers, antecedents, and crisis cycle;*
6. *strategies for preventing retraumatization, including adjusting rules or disciplinary practices that can be triggering;*
7. *responding to aggression or assaultive behavior; and*
8. *repairing the treatment parent-child relationship after conflict or crisis.*

Examples: *Educational advocacy skills may include:*

1. *maintaining relationships with teachers and administrators;*
2. *monitoring attendance and academic performance;*
3. *participating in collaborative planning around academic goals, behavior support, and extracurricular activities;*
4. *advocating for additional social and educational supports;*
5. *staying up-to-date on school policies and programs that could affect the child; and*
6. *ensuring prompt response to harassment or discrimination.*

FKC 13.10 (FP)

Treatment foster parents receive the support they need to carry out their role, including:

a. weekly contact by the assigned worker;
b. in-person contact every two weeks and more frequently when indicated;
c. on-call crisis intervention 24-hours a day, seven days a week;
d. routine follow-up on training topics and competencies;
e. respite care;
f. resources for recognizing and coping with secondary trauma and stress; and
g. the availability of additional personnel and technical assistance, as needed.

Interpretation: *Additional personnel should be available during critical or stressful periods, such as the time from the end of the school day until bedtime.*

Examples: *More frequent in-person contact may be indicated during periods of transition, such as in the initial six weeks of placement, and when changes occur to the child's level of care or treatment team, which can be triggering for children and stressful for treatment parents.*

FKC 13.11

Discharge reports are tailored to support the child's transition to the next care setting, and document:

a. the course of treatment and treatment recommendations;
b. the transfer of records and appointment information; and
c. the nature, frequency, and duration of aftercare services, when applicable.

NA: The organization provides Foster Care Home Services only.

Family Foster Care and Kinship Care

FKC 14: Worker Contact and Monitoring

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Workers maintain regular contact with children, parents, resource families, and collaborating organizations and agencies to establish positive relationships that promote safety, well-being, and progress towards service and permanency goals.

Interpretation: *When the organization is working with American Indian and Alaska Native children and families representatives from tribes or local Indian organizations should be informed of regular contact with children, caregivers, and families and be given an opportunity to participate.*

Note: *For organizations that provide Foster Care Home Services the worker is the staff person that carries a caseload of resource families.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Procedures for worker contact and meetings in the home	
*	• Procedures for maintaining contact with other service providers and systems	
*	• Procedures for preventing and responding to missing children	
*	• Procedures for responding to allegations of maltreatment in resource families	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Foster parents
    4. Parents
    5. Children and youth

- Review case records
- Review resource parent records
- Observe system that maintains information about children's current placements

FKC 14.01 (FP)

Meetings with children, parents, and resource parents:

a. occur at least once a month;
b. happen on a consistent, scheduled basis at mutually agreed upon times, whenever possible;
c. take place primarily in the home (parent or resource family); and
d. include time for private discussion with all parties to ensure both children and their caregivers can feel comfortable sharing information.

Interpretation: *When treatment foster care is provided, workers should meet with children and resource families at least twice per month, consistent with FKC 13.10.*

The first meeting with the resource parents should occur within the first two weeks of placement, consistent with the assessment timeframes outlined in FKC 4.01.

When no children are placed in a resource family's home, or if the organization only provides Foster Care Home Services, meetings with resource families in the home may occur less than monthly, but at a minimum on a quarterly basis.

Examples: *While regular visits will occur on a consistent, scheduled basis, some organizations may also make one unannounced visit per quarter.*

FKC 14.02

Upon placement in foster care or move to a new resource family home, the worker meets with children and resource families in the new home within three days.

NA: The organization provides Family Foster Care Home Services only.

Interpretation: *When treatment foster care is provided children should be seen on the first day of placement.*

FKC 14.03

Contacts with children and parents are used to:

a. cultivate strong, supportive, and productive relationships;
b. monitor and promote safety, permanency, and well-being; and
c. share information about the children, and facilitate parental involvement in children’s care and activities.

NA: The organization provides Family Foster Care Home Services only.

Interpretation: *Parents should be encouraged to participate in their children's health appointments, school activities, and other events, and involved in everyday decision making whenever possible, unless contraindicated*

Interpretation: *Service monitoring should include confirming that services were initiated and are appropriate, and responding to complaints or problems that develop regarding service delivery.*

Note: *For organizations that do not provide services to parents, element (c) does not apply, and elements (a) and (b) apply only to worker contact with the child.*

FKC 14.04

Workers regularly consult with resource parents to:

a. maintain positive relationships;
b. monitor and promote safety and well-being;
c. share all relevant and legally permissible information concerning the children;
d. clarify their role in supporting and contributing to the service and permanency plan;
e. inform them about, and encourage their participation in, upcoming team meetings and court hearings, as appropriate;
f. provide ongoing feedback regarding performance that includes attention to both strengths and needs;
g. assess whether additional assistance or support is needed; and
h. respond to questions, concerns, and issues, as needed.

Interpretation: *Safety monitoring should include attention to potential concerns including: inadequate or unsafe heat, light, water, refrigeration, cooking, and toilet facilities; malfunctioning smoke detectors; unsanitary conditions; lack of phone service; unsafe doors, steps, and windows, or missing window guards where necessary; exposed wiring; access to hazardous substances, materials, or equipment; rodent or insect infestation; walls and ceilings with holes or lead; and insufficient space.*

Interpretation: *While support and consultation will be provided during the regularly scheduled visits described in FKC 14.01, workers must also respond to questions and requests for assistance between visits.*

Examples: *Regarding element (a), factors that can positively influence resource family retention and satisfaction with worker contact include:*

1. *reliable appointment scheduling and follow-up;*
2. *receptiveness to feedback;*
3. *flexibility;*
4. *advocacy;*
5. *open communication; and*
6. *recognition of the resource parents' relational role.*

FKC 14.05

Workers actively partner with families to ensure effective service coordination by:

a. helping family members access needed services and navigate different systems;
b. communicating with children, parents, and resource families to monitor service delivery, including confirming that services were initiated and are appropriate, and responding to complaints or problems;
c. communicating with other workers and/or service providers in a regular and timely manner to share information and monitor service participation and progress;
d. ensuring appropriate communication and coordination among the other providers serving children and families;
e. facilitating timely and consistent referrals for assessments and services; and
f. mediating barriers to services within the service delivery system.

Interpretation: *With regard to element (d), personnel should follow formal procedures for working with service providers and sharing relevant information about a case internally when different workers are responsible for different components of service, or when responsibility for the case is transferred to a different worker. Communication among providers is especially critical when providers work with family members regarding specific issues that may impact safety, such as substance use, mental health, and domestic violence.*

FKC 14.06 (FP)

Current information about children's placements is updated within 24 hours of any change and available to authorized personnel at all times.

FKC 14.07 (FP)

The organization collaborates with law enforcement, public agencies, tribal governments, and other community resources to establish procedures for preventing and responding to missing children that address:

a. creating an environment that provides a sense of safety, support, and community;
b. assessing risk of abduction or running away;
c. immediately reporting missing children to the organization, law enforcement, and parents;
d. working in partnership with law enforcement to find missing children, and protocols for sharing and releasing information needed to assist in a search;
e. welcoming, screening, debriefing, and conducting event-based re-assessments, including re-entry examinations and clinical consultations when children return; and
f. addressing issues that led to the episode or that arose while children were missing by providing needed supports and ensuring appropriate placements, including new placements when necessary.

FKC 14.08 (FP)

Procedures for responding to allegations of maltreatment by a resource family:

a. respect the rights and needs of children, their families, and the resource family under investigation;
b. address the process for investigation, appeal, and resolution;
c. address access to resources or services that can provide support throughout the investigation process; and
d. are developed in collaboration with law enforcement, tribal governments, and other community agencies, and incorporate input from resource families.

FKC 14.09 (FP)

When children are reunified with their families, they are visited in the home on the day following return to confirm safety.

NA:

- The organization has a contract with a public authority that prohibits or does not include aftercare or follow-up upon reunification.
- The organization provides Foster Care Home Services only.
- The organization does not work with families who will be reunifying.

Family Foster Care and Kinship Care

FKC 15: Transition to Adulthood

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Youth are supported in their transition to adulthood through individualized planning and preparation that promote well-being, strong support systems, access to needed resources, and skill development.

NA: The organization does not serve youth 14 or older.

Note: *The transition to adulthood refers to both the developmental life stage and the transition out of the foster care system. FKC 15.01 - FKC 15.06 apply to all youth in care who are approaching adulthood, regardless of their plans for permanency. In cases where youth will transition from the system without having achieved legal permanency, FKC 15.07 and FKC 15.08 will also apply.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Procedures for transition planning including collaborating with other service providers	
*	• Procedures for assessing independent living skills	
*	• Independent living skills assessment tool	
*	• Procedures for developing shared living agreements	

Site Visit Evidence

*

- Informational materials provided to youth

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Youth
    4. Resource parents

- Review case records

FKC 15.01

Preparation for adulthood begins well in advance of a youth's transition and:

a. ensures maximum youth participation in all aspects of exploring and planning for the future;
b. includes adults and peers important to the youth; and
c. involves collaboration and coordination among all service providers.

Interpretation: *For youth who will be transitioning into adult systems of care, planning meetings and discussions should include providers from the adult-serving systems that will be working with the youth. This is especially critical for youth with developmental disabilities or mental health needs.*

Examples: *Adults and peers that are important to youth can include family members, friends, and natural mentors.*

FKC 15.02

Preparation for adulthood is a strengths-based process that promotes safety, permanency, and well-being by helping youth explore:

a. their family relationships, including the family's readiness for healthy participation in the youth's life;
b. relationships with supportive peers and adults, including involved adults' commitment to the youth;
c. strategies for coping with and healing from stress and trauma associated with grief and life transitions;
d. the range of housing options available to them, including tribal options for American Indian and Alaska Native youth, as well as the risks and benefits of different housing options;
e. their academic needs and interests and available educational paths; and
f. their work interests and skill sets, as well as different interests, career paths, and employment supports.

Examples: *Housing options may include the full range of living situations from supported living to fully independent living environments.*

FKC 15.03

The organization works with youth, parents, and resource families, to assess the independent living skills of youth 14 years and older, at regular intervals using a standardized assessment instrument that includes the following areas:

a. educational and vocational development;
b. interpersonal skills;
c. financial management;
d. household management; and
e. self-care.

Interpretation: *The first assessment should be completed as soon as possible after children's 14th birthdays to establish a benchmark for measuring progress in identified areas. Systematic assessment normally reoccurs at 6- or 12-month intervals.*

FKC 15.04

The organization ensures that youth transition to adulthood with basic social supports, including:

a. strong, consistent relationships with committed, caring adults;
b. access to cultural and community supports; and

c. connections to positive peer support.

Examples: *The organization can facilitate continued connection between youth and their former resource families, who can offer youth valuable, lasting support even if legal permanency was not achieved.*

FKC 15.05

The organization assists youth in obtaining or compiling documents necessary to function as an independent adult, including, as appropriate:

a. an identification card or driver's license, when the ability to drive is a goal;
b. a social security or social insurance number;
c. a resume describing their work experience and career development;
d. an original copy of their birth certificate;
e. bank account access documents;
f. religious documents and information;
g. documentation of immigration or refugee history and status;
h. documentation of tribal eligibility or membership;
i. death certificates if parents are deceased;
j. a life book or a compilation of personal history and photographs;
k. a list of known relatives, with relationships, addresses, telephone numbers, and permissions for contacting involved parties;
l. information about places they have lived (previous placement information);
m. educational records, such as high school diploma or general equivalency diploma, and a list of schools attended; and
n. health and mental health records, including the names and addresses of youths' doctors, as well as information regarding any special needs and appropriate treatment, including medication, as applicable.

FKC 15.06

When youth continue to live with foster families past the age of 18, shared living agreements are developed in advance of youths' 18th birthdays to promote independence, clarify new roles, and establish mutually agreed upon expectations.
Interpretation: *In a developmentally appropriate manner, every youth turning 18 should be engaged in a conversation, documented in the case record, that explores and determines the mutual expectations and responsibilities of the living arrangement now that they are not a minor.*

FKC 15.07

At least six months before they will transition from care, the organization helps youth who will transition from the system without achieving legal permanency develop individualized plans for transition, by addressing the following areas:

a. housing and transportation;
b. education and academic support;
c. employment and workforce support;
d. finances/income, including public assistance when available;
e. health insurance;
f. physical and behavioral healthcare, including needed medical, dental, mental health, and substance use treatment;
g. transitioning to adult systems of care for mental health or developmental disabilities, when applicable;
h. services and supports available to youth who were in foster care for education and independent living activities;
i. social, peer, cultural, and community supports, including support or mentoring available through community volunteers or individuals who have made a successful transition;
j. legal rights and requirements regarding consent to remain in care beyond the age of 18, if applicable; and
k. how to contact the organization and what supports the organization can offer after case closing, including information regarding voluntary return to care, as appropriate.

Interpretation: *Transition planning for youth in treatment foster care should address self-care, medication schedules, and how to recognize symptoms that require medical or clinical attention.*

Interpretation: *In regards to element (g), transition planning meetings should include representatives from the adult-serving systems that will be working with youth, and the organization should partner with the providers to facilitate access to services.*

FKC 15.08

The organization provides youth who transition from the system without achieving legal permanency with at least six months advance notice of the cessation of any health, financial, or other benefits that may occur at transition or case closing.

Family Foster Care and Kinship Care

FKC 16: Family Reunification

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Children and families receive the support and services they need to ease the transition to reunification, stabilize the home, and prevent re-entry into out-of-home care.
NA: NA The organization does not work with families who will be reunifying.

Interpretation: *COA recognizes that in instances where the court suddenly orders a child home without advance notice, the organization will not be able to fully implement all the practice standards in this section. However, the organization should still try to implement the standards to the extent possible. For example, while the organization may not be able to develop an individualized transition plan prior to reunification as per FKC 16.02, it should collaborate with the family to develop the plan as soon as possible after reunion.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Procedures for preparing children, parents, and resource families for reunification	
*	• Procedures for reunification planning, monitoring, and support, including procedures for referring children and families to post-reunification services	

Site Visit Evidence

*	• Community resource and referral list

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Parents served
    4. Children served
    5. Resource parents

- Review case records
- Review resource parent records

FKC 16.01

In an effort to facilitate a smooth transition to family reunification:

a. children and parents are involved in making decisions regarding reunification;
b. children, parents, and resource families are provided with sufficient advance notice that children will return home;
c. a graduated process for family time enables both children and parents to prepare for reunification; and
d. collaborating service providers are involved in preparation for reunification and notified when reunification has occurred.

Examples: *Procedures regarding the transition to reunification may vary but organizations often utilize a graduated step-down process that includes home visits, extended home visits, and trial discharge.*

FKC 16.02

Parents are prepared for the return of their children and the challenges of reunification through support and guidance that help them to:

a. understand expectations and responsibilities related to their children's return;
b. develop strategies for providing appropriate care, managing children's behavior, meeting any special needs children may present, and preventing reoccurrence of the safety concerns that led to the separation of the children;
c. consider how everyday living and family relationships will be impacted by their children's return;
d. understand how children may react and behave as they adjust to the return home; and
e. explore any anxiety, uncertainty, or ambivalence they may feel about responsibilities related to their children's return.

NA: The organization, by virtue of law or contract, does not serve parents.

Examples: *In treatment foster care, treatment parents may support reunification by sharing information with birth parents about their child's treatment progress, and supporting birth parents to develop strategies for managing their child's conditions and navigating specialized service providers and the school system.*

FKC 16.03

Children receive individualized, age- and developmentally- appropriate support and guidance that helps them explore their feelings about reunification, and prepare for the return home.
Examples: *The support and guidance provided may vary in amount or type depending on children's circumstances, including length of time in out-of-home care. Topics to discuss may include, but are not limited to: the child's experiences while in out-of-home care, including a review of the child's life book; the reunification process; expectations for the return home; any protections in place to ensure the child's safety; any fear or anxiety the child may be experiencing; and coping with any grief or loss the child may experience upon leaving a resource family. While support and guidance may be provided by workers, resource families may also play an important role in preparing a child for reunification.*

FKC 16.04

The organization collaborates with resource families to:

a. explain their role in supporting and facilitating reunification;
b. help them explore and cope with any anxiety, grief, or other emotions they may feel as a result of the decision to reunify the family; and
c. clarify whether there will be opportunities for contact with children following reunification.

FKC 16.05

Parents are provided with needed documents and information related to their children's time in care, including:

a. legal documents;
b. educational records, including copies of report cards and the most current Individualized Education Plan (IEP);
c. health and mental health records, including the names and addresses of children's doctors, as well as information regarding any special needs and appropriate treatment, including medications, as applicable; and
d. a written summary of children's placements, experiences, and growth while separated from their families.

FKC 16.06

Prior to reunification, the organization collaborates with families to develop individualized plans for promoting family stability after reunion, by addressing:

a. the issues, behaviors, and conditions that led to the involvement of the child welfare system;
b. any issues stemming from children's separation from their families, including any assistance needed to address separation and rebuild the parent-child relationship; and
c. any additional formal and informal services and supports that the children and family may need.

Interpretation: *The plan for maintaining family stability after reunification will likely be an extension of the family's service plan. While plans should be developed prior to reunification, they should also allow for flexibility based on changing needs and circumstances.*

Examples: *Families often have both concrete and clinical needs, and may need help addressing many of the same issues and challenges that led to the involvement of the child welfare system in order to prevent re-entry. Services may be needed by both parents and children, and may include, but are not limited to: substance use treatment; mental health treatment; counseling; medical and dental care; educational advocacy and supports; specialized medical, mental health, or educational supports for children with special needs; child care; respite care; income support; housing assistance; transportation; homemaker assistance; vocational assistance; case management; mentoring; and support groups. Sources of informal and social support (e.g., extended family, neighbors, and other community members and institutions) may help to support the family over time, even after the case has been closed.*

FKC 16.07

Upon reunification children and families receive services, support, and monitoring for a period of time specified by the organization or court, and until case closing criteria are met.
NA: The organization, by virtue of law or contract, does not provide post-reunification services.

Examples: *To promote family stabilization and prevent re-entry to out-of-home care, services are often recommended to be maintained for at least 12 months after reunification. Families reunifying from treatment foster care may need additional time and support to adjust to the child's behavioral, emotional, or medical needs.*

Family Foster Care and Kinship Care

FKC 17: Resource Family Recruitment

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

The organization recruits diverse resource families to maximize opportunities for children to be placed in a family setting that effectively meets their needs.

NA: The organization has no role in resource family recruitment or assessment.

Examples: *Recruitment activities may include child-specific and kin recruitment as well as recruitment for traditional foster care.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Eligibility criteria	
*	• Resource family recruitment plan	

Site Visit Evidence

*	• Aggregate report of recruitment/retention data for the past 12 months • Recruitment materials • Resource family orientation curricula and/or materials

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Resource parents

- Review resource parent records

FKC 17.01

The organization establishes an annual resource family recruitment plan that:

a. is based on the collection and analysis of local data on the needs and characteristics of children in care, existing resources, and characteristics of successful resource families;
b. identifies targeted recruitment strategies corresponding to greatest identified needs;
c. establishes a framework for child-specific recruitment; and
d. is evaluated annually.

NA: NA The organization provides kinship care services only.

Examples: *Organizations can use data to inform recruitment plans by tracking activities with the highest efficacy and associated outputs, such as completion of training, successful licensure, successful placement, and retention; and milestones in the recruitment or approval process that correlate with disengagement.*

Examples: *A recruitment plan may specify how carefully crafted language, images, and strategies, including the establishment of key partnerships, can help the organization reach out and appeal to audiences who may be willing and able to foster or adopt children in need of homes, including children with special placement needs (e.g., sibling groups; older children; children with physical, emotional, behavioral, and developmental challenges; children of minority racial or ethnic groups; children who identify as LGBTQ+; and youth who are pregnant or parenting.)*

Targeted recruitment strategies can include:

1. *looking for prospective resource parents for youth among high school parents and coaches, and after-school programs for teens;*
2. *engaging specific cultural organizations, churches, or minority-owned businesses to recruit resource families from particular ethnic or racial groups;*
3. *engaging specific LGBTQ+ community groups, attending LGBTQ+ community events, or reaching out to inclusive faith-based communities to recruit LGBTQ+ resource families;*
4. *partnering with tribes and Indian organizations and establishing joint recruitment efforts to identify families for American Indian and Alaska Native children; and/or*
5. *outreach to healthcare professionals, individuals with experience working with people with disabilities, and accessible housing communities to recruit resource families for children with disabilities or acute medical conditions.*

Other key partners can include:

1. *family foster care alumni;*
2. *current resource parents, especially for treatment foster care or LGBTQ+ recruitment;*
3. *community leaders; and*
4. *other organizations, agencies, institutions, and businesses in the community.*

Intensive child-specific recruitment strategies include identifying all adults with a connection to the child who could potentially serve as resource parents and involving the child to identify preferences and potential resource parents.

FKC 17.02

To help prospective resource families determine if providing care would be a positive experience for both their family and the children that could enter their care, the organization provides general, culturally-responsive information about:

a. eligibility requirements;
b. the certification process, timeline, and requirements, including the resource family training and assessment experience;
c. available supports and services;
d. any applicable fees and reimbursements;
e. the roles, responsibilities, and needed competencies of resource parents;
f. what resource families should expect when they take in a child;
g. common needs and characteristics of children in care in the local community;
h. the organization's treatment and parenting philosophies; and
i. next steps in the process.

Examples: *Implementation of element (h) can include providing information about the basic principles of trauma-informed care and positive behavior support.*

FKC 17.03

Prospective resource families are engaged in the recruitment process through:

a. a welcoming and supportive approach;
b. equitable, timely, sensitive, and culturally-responsive support and follow-up at each step of the process;
c. personalized contact with existing resource families; and
d. open houses, orientations, and training sessions that are accessible and inviting to all prospective resource families.

Examples: *Contact with existing resource families, including the use of peer mentors, can support recruitment and preparation for the resource family role by providing prospective resource families with opportunities to:*

1. *better conceptualize the needs of children in care and the lived experience of caring for them;*
2. *observe, practice, and be coached on parenting techniques and/or treatment interventions through role play or real-life scenarios;*
3. *affirm their capacity to grow into the role and successfully develop new competencies;*
4. *learn about available support networks and resources; and*
5. *ask questions or voice concerns they are reluctant to share with workers.*

FKC 17.04

Resource parent recruitment is ethical and equitable, and eligibility criteria:

a. prioritizes the needs and varying characteristics of children in care;
b. promotes inclusion of individuals and families with diverse backgrounds to ensure appropriate placement options are available for all children; and
c. emphasizes the skills and capacities needed to provide a safe, supportive home environment.

Interpretation: *If eligibility criteria is limited, the organization must have a policy for such selectivity and refer applicants who do not meet its criteria to another provider, unless it is evident the applicants do not meet legally required criteria.*

Family Foster Care and Kinship Care

FKC 18: Resource Family Assessment and Approval

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

The resource family assessment process ensures that prospective resource families are willing and able to meet the needs of children and their families.
NA: The organization has no role in resource family assessment or approval.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Non-kin resource family assessment procedures	
*	• Kinship resource family assessment procedures	
*	• Copy of kinship and non-kin resource family assessment tool(s)	
*	• Procedures for vehicle use, including license validation, insurance coverage expectations, etc.	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Resource parents

- Review resource parent records

FKC 18.01

The resource family assessment is a standardized, collaborative process that is conducted in a culturally-responsive manner using a defined method and tools.

Interpretation:*While practice should be consistent with the program model, tools, and standards, decisions about how the assessment is conducted in each case are clinical decisions that should take into account the unique needs and circumstances of the prospective resource parents (and the child if the child is already identified or living in the home). Assessments may be structured differently if they are conducted for kin (as opposed to non-kin prospective resource parents) or treatment parents. The organization should have a system or approach that recognizes that there can be subjective aspects to assessment and decision-making, and appropriate mechanisms to ensure that its determinations are well justified.*

FKC 18.02 (FP)

The assessment process for non-kin resource families includes:

a. the receipt of self-reported information and documents from the prospective resource parents;
b. at least one individual in-person consultation with each prospective resource parent and one joint consultation for joint applicants;
c. age and developmentally appropriate consultation with each child or adult child of the prospective resource parents living outside the home;
d. at least two visits to the prospective resource family's home, and during one or more of those visits a safety assessment of the home and an observation of family members interacting together;
e. criminal background, child abuse and neglect, and sex offender registry checks for all adults living in the home in accordance with applicable law and regulation;
f. a review of the information and documents related to any previous unfavorable resource family assessments, disruptions, dissolutions, or placement of other children out of the home; and
g. references and interviews with individuals providing references, including at least one from an individual with direct knowledge of the prospective resource parents' capacity to care for children.

1. **Interpretation:***The safety assessment of the home should include attention to potential concerns including: inadequate or unsafe heat, light, water, refrigeration, cooking, and toilet facilities;*
2. *malfunctioning smoke detectors;*
3. *unsanitary conditions;*
4. *lack of phone service;*
5. *unsafe doors, steps, and windows, or missing window guards where necessary;*
6. *exposed wiring; access to hazardous substances, materials, or equipment;*
7. *rodent or insect infestation;*
8. *walls and ceilings with holes or lead; and*
9. *insufficient space.*

Interpretation: *The organization should develop criteria for the review of criminal background checks that specify if, and when, checks are conducted on a multi-state or national basis, and how the organization evaluates and responds to reports indicating criminal offenses. Prospective resource families should be informed at the beginning of the process about the organization's policy regarding criminal convictions. Each situation should be assessed on a case-by-case basis.*

FKC 18.03 (FP)

The assessment process for kin resource families includes:

a. criminal background, child abuse and neglect, and sex offender registry checks for all adults living in the home;
b. an assessment of the physical safety of the home;
c. an assessment of the kinship caregiver's ability to meet the physical, emotional, medical, and educational needs of the child or youth; and

d. assistance with making the necessary safety modifications and/or obtaining items needed to accommodate the child or youth.

Interpretation: *To remove additional barriers and encourage placement with kin, the approval process may be structured differently for kin than for non-kin prospective resource parents. However, consistent with the Adam Walsh Act, name-based criminal and child abuse background checks and same-day preliminary safety assessments must be conducted prior to placement. The approval process for kin should include:*

1. *initiation of a national fingerprint-based criminal background check for all prospective kinship caregivers;*
2. *a name-based criminal background check for all adults living in the home;,*
3. *a state child abuse and neglect registry check for all adults living in the home;*
4. *initiation of a child abuse and neglect registry check for all states where the adults in the home have lived in the last five years;*
5. *a sex offender registry check for all adults living in the home; and*
6. *a preliminary safety assessment of the physical home.*

Organizations may have more flexibility to make exceptions around certain non-violent criminal or civil background histories for kin who are otherwise determined to be appropriate caregivers. The organization should develop criteria for evaluating and responding to reports indicating criminal offenses and communicate these policies to prospective kinship caregivers.

Interpretation: *Regarding element (b), the home assessment should focus on basic safety elements such as the availability of clean water, a heating and/or cooling system as appropriate to the region, electricity and lightning based on the child's specific needs, safe sleeping arrangements, sanitation, and proper storage of weapons and hazardous materials. The kinship caregiver can be approved without first obtaining certain safety elements such as a smoke or carbon monoxide detector or specific infant care items.*

Examples: *Please see the Kin-Specific Foster Home Approval: Recommended Standards of National Organizations for more information on kinship caregiver assessment.*

FKC 18.04

Workers collaborate with prospective resource families to explore factors that may impact their ability to provide effective care and offer experiences that enhance healthy development, including:

a. motivation and expectations for providing resource family care and interest in adoption, if applicable;
b. personal characteristics such as adaptability, reliability, and coping, communication, and problem-solving skills;
c. caregiving abilities and experiences, especially for children or adults with significant or complex needs;
d. willingness and ability to provide safe, nondiscriminatory, and supportive care to specific populations such as LGBTQ+ youth, older youth, or youth with complex social, behavioral, emotional, or medical needs;
e. willingness to provide trauma-informed care;
f. willingness to collaborate with birth parents and support children's ties to culture, family, peers, and community;
g. willingness and ability to work as a member of a team to support and facilitate permanency for children in care; and
h. previous experiences with foster care, kinship care, or adoption.

Interpretation: *When the prospective resource family is known to the child, the assessment should also evaluate the relationship between the prospective resource family and the child, the child's relationship to individuals already living in the home, and the prospective resource family's commitment to the child.*

FKC 18.05 (FP)

The assessment process explores each prospective resource parent's:

a. personal history of trauma, abuse, or neglect;
b. current status and history of physical and mental health, including substance use;
c. social support systems;
d. education;
e. functional literacy and language skills;
f. employment history, and financial status; and
g. community and social environment.

Interpretation: *Regarding element (b), a written statement from a physician or other qualified health professional regarding the person's health is acceptable to meet the intent of the standard. If the assessment indicates a mental health concern, the individual must also obtain a formal evaluation from a mental health professional. Prospective resource parents who are undergoing appropriate treatment or in recovery should not automatically be excluded from consideration or approval.*

The organization should consult with the local public health authority to determine if a skin tuberculin test should be included in the assessment. Special circumstances, including the health needs of the resource parent, may indicate a need for re-assessment prior to the annual re-assessment.

Interpretation: *When working with kin, organizations have the discretion to waive elements in the assessment process to encourage placement with kin.*

FKC 18.06 (FP)

The organization ensures that resource parents who will transport children in their own vehicles:

a. use age-appropriate passenger restraint systems;
b. provide adequate passenger supervision, as required by statute or regulation;
c. properly maintain vehicles and obtain required registration and inspection;
d. provide the organization with annual validation of their driving records; and
e. provide the organization with regular validation of their licenses and appropriate insurance coverage.

NA: The organization works with kinship caregivers only.

Interpretation: *Regarding element (e), this information should be provided as frequently as necessary, based on the amount of time licenses and insurance are valid. The organization should determine what level of insurance coverage is considered appropriate and maintain a copy of each resource parent's auto policy declaration to validate appropriate insurance coverage.*

FKC 18.07

During the assessment process kinship caregivers have the opportunity to:

a. discuss their families' stories and the experiences that brought them to becoming or planning to become kinship caregivers;
b. discuss their concerns with becoming licensed, approved, or certified resource parents;
c. discuss the impact of the kinship caregiver role on their relationship to the birth parents and the child; and
d. learn how the program collaborates with kinship caregivers and supports relationships between kinship families, parents, and extended families.

NA: The organization does not have a role in assessing kinship caregivers.

FKC 18.08

Based on the information obtained during the assessment of a prospective resource family, the organization prepares a report:

a. indicating whether the prospective resource family has the ability, willingness, and resources to meet the needs of children in care; and
b. within timeframes established by the organization, and prior to a child joining the resource family.

Interpretation: *Regarding element (b), placement with a kinship caregiver can occur prior to the completion of a report.*

FKC 18.09 (FP)

The organization ensures that all resource family homes receive and maintain licensure, approval, or certification in accordance with state, tribal, or local regulation.

FKC 18.10 (FP)

Resource family assessments are updated:

a. within two weeks of a reported change in the home composition; and
b. at least once annually.

Examples: *Changes that may warrant a follow-up assessment may include, but are not limited to: individuals moving in or out of the home; death or debilitating illness of a caregiver; structural defects in the home related to fire, flood, or natural disaster; or legal proceedings affecting the resource family such as eviction or divorce. The annual assessment update can occur in conjunction with the annual resource parent evaluation.*

Family Foster Care and Kinship Care

FKC 19: Resource Family Training and Preparation

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Resource families receive training and preparation to strengthen their capacity to care for children and support children's families.

Interpretation: *Training and other preparation activities should be structured to offer prospective resource parents exposure to real-life examples of caring for children that come into care, such as children who have experienced trauma and maltreatment and/or may exhibit emotional/behavioral challenges.*

Interpretation: *While the training and other preparation activities outlined in FKC 19.01 to 19.04 are not required for kinship caregivers to obtain or maintain their approval or license, the organization should offer voluntary, ongoing training and support on topics relevant to kinship caregivers at a frequency and in a format that meets their needs. Topics covered should reflect the training needs identified in the kinship caregiver assessment of strengths and needs, FKC 21.04.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• List of required training for non-kin resource parents (including specific requirements for foster parents and treatment foster parents, as applicable) including specifications regarding pre- and in-service training requirements	
*	• Table of contents for training curricula	

*	• Emergency response procedures	
*	• Procedures for evaluating training effectiveness	

Site Visit Evidence

*

- Materials provided to resource parents describing their rights and responsibilities
- Training curricula
- Documentation tracking completion of required trainings for non-kin resource parents
- Documentation of trainings or supports offered to kinship resource parents
- Sample of emergency protocols from non-kin resource homes, if resource parents develop individualized plans
- Results of evaluation of training effectiveness

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Resource parents
- Review resource parent records

FKC 19.01 (FP)

Resource parents receive pre-service training on rights and responsibilities that addresses:

a. the organization's mission, logic model or equivalent framework, and service array;
b. the rights of children in care;
c. what resource families should expect when they take in a child;
d. the competencies needed for effective resource parenting, and how those competencies are integral to the organization's logic model or equivalent framework;
e. specific duties of resource parents, including administrative responsibilities;
f. available supports and services;
g. identification and reporting of abuse and neglect;
h. any fees or reimbursement for services, including compensation for damages caused by children placed in the home, as applicable;
i. notice of and participation in any review or hearing regarding the child;
j. procedures when allegations are made, and ways to prevent false allegations;
k. complaint procedures; and
l. circumstances that will result in revoking a resource family license or certification.

FKC 19.02 (FP)

Resource parents receive pre-service training that addresses:

a. strategies for providing support appropriate to children's ages and developmental levels;
b. promoting positive behavior and healing through coaching, nurturing, and positive discipline techniques;
c. recognizing and responding to behaviors that jeopardize health and well-being, including de-escalation techniques;
d. signs and symptoms of trauma, including triggers/antecedents for challenging behaviors;
e. providing protection and promoting psychological safety to mediate the effects of trauma, maltreatment, separation, loss, and exploitation; and
f. preventing and responding to missing children, including understanding factors that may contribute to the decision to run away, reporting protocols, and how to support children upon their return.

Interpretation: *Regarding element (f), educating resource parents on sex trafficking is a critical component to prevention, identification, and treatment. Education should address topics such as internet safety, how to respond when a child runs away, and developing healthy relationships. Additionally, education should emphasize the issue of stigma associated with prostitution to help resource families provide healthy, nonjudgmental home environments that are supportive of a successful reintegration.*

FKC 19.03

Resource parents receive pre-service and ongoing training and support to demonstrate competency in:

a. supporting and facilitating children's emotional, physical, and legal permanency;
b. meeting children's developmental needs across life domains, including addressing any developmental delays;
c. providing safe, non-discriminatory, and supportive care to a child of a different race, ethnicity, culture, religion, sexual orientation, or gender identity;
d. supporting children's social identity development;
e. supporting and facilitating family relationships, friendships, cultural ties, and community connections;
f. collaborating with family team members and service providers; and
g. managing the caregiver role, stress and self-care, and the impact on the family.

Interpretation: *Regarding elements (d) and (e), training should include educating resource parents on the Indian Child Welfare Act, its impact on placement and permanency for American Indian and Alaska Native children, and the resource parents' responsibilities for supporting the child's cultural identity and facilitating connections to their tribe.*

Interpretation: *Resource families caring for parenting youth placed together with the youths' children should also receive training and support to demonstrate competency in modeling positive parenting practices, supporting youth parents to meet their children's needs, and meeting the dual developmental needs of the parenting youth and their children.*

Examples: *To promote culturally competent care, training may address: (a) the organization's nondiscrimination policy; (b) the history, traditions, values, and communication styles of populations served; (c) systemic inequities and implicit bias; (d) how culture influences trauma response; (e) a review of vocabulary relevant to LGBTQ+ youth; and (f) caregiver behaviors that promote the safety and well-being of LGBTQ+ youth.*

Examples: *Family foster care programs that work with kinship and non-kin resource parents may find it valuable to provide separate training for kinship caregivers to provide a space in which kinship caregivers can relate to each other and apply the training to their specific experiences of caring for their kin.*

If resources do not allow for separate training, the training facilitator can work to incorporate the experience of both groups into the training. Training facilitators can follow up with kinship caregivers about their concerns and the training experience to ensure that their particular concerns can be addressed in the training or at another time by the staff working with their family. Some of the specific training and support needs of kin may relate to negotiating family dynamics, the experience of family trauma, managing boundaries, and discipline traditions.

FKC 19.04 (FP)

Resource parents are trained in;

a. first aid and age-appropriate CPR at least every two years, including a hands-on, in-person CPR skills assessment conducted by a certified CPR instructor;
b. medication administration, including retraining at least every two years;
c. protocols for responding to emergencies including accidents, serious illnesses, fires, and natural and human-caused disasters; and
d. medical or rehabilitation interventions and operation of medical equipment required for a child's care, as needed.

Interpretation: *Regarding element (b), training should address the use of psychotropic medications with children and youth in foster care, the resource parents' role in communicating with prescribers and monitoring symptoms and side effects, and how to recognize and raise concerns around dosage, polypharmacy, and age-related contraindications.*

FKC 19.05 (FP)

Resource parents sign a statement indicating that for children placed in their care they agree to:

a. report suspected abuse and neglect;
b. employ positive discipline techniques;
c. refrain from using physical and degrading punishment; and

d. ensure that others refrain from using physical and degrading punishment.

FKC 19.06

The organization evaluates the effectiveness of its training and support programs, identifies areas for improvement, and develops a plan to address unmet needs.

Examples: *Evaluating the effectiveness of training and support programs and identifying emerging training or re-training needs can be done through: (a) the organization's annual mutual review with the resource family; (b) satisfaction surveys; (c) reviews of critical incidents; and (d) analysis of the characteristics and diagnoses of children in care.*

Improvement plans may include enhancing existing standardized training modules, offering supplemental in-service trainings, or strengthening relevant competencies through worker contact.

Family Foster Care and Kinship Care

FKC 20: Resource Family Use of Physical Interventions

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Resource parents who use physical interventions are trained and supported by the organization to deploy them in a manner that ensures safety and well-being when positive behavior support and de-escalation measures have proven ineffective in crisis situations.
NA: The organization does not permit resource families to use physical interventions.

Interpretation: *Physical interventions do not include actions in response to age- or development-related behaviors demonstrated by young children such as physically holding a three-year-old who tries to run into the street.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Behavior support policy	
*	• Behavior support procedures	
*	• Table of contents for resource parent physical intervention training curriculum	

Site Visit Evidence

*	• Training curriculum	

- Documentation tracking completion of required trainings and evaluation
- Documentation of incident reporting and review

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Resource parents

- Review resource parent records
- Review case records

FKC 20.01

The organization's policies and procedures:

a. prohibit the use of locked seclusion and mechanical restraints by resource families;
b. define which physical interventions resource families are and are not allowed to use, and under what circumstances; and
c. outline what to do following an incident.

Interpretation: *The policy and procedures align with the information the organization provides families in ASE 2.01. Given that COA Accreditation's standards prohibit the use of locked seclusion by resource families, resource parents should never lock a child in a room. If there are concerns about the child's safety, the resource family should consult with the case worker and behavior support plan for alternative options.*

FKC 20.02 (FP)

Physical interventions are discontinued as soon as possible and are prohibited from use:

a. by anyone other than the resource parents or other adult caregivers who have been approved by the organization;
b. as a form of punishment or discipline;
c. for the convenience of resource parents;
d. in response to property damage that does not involve imminent danger to self or others;
e. when contraindicated in the child's behavior plan;
f. for longer than 15 minutes for children aged nine and younger; and
g. for longer than 30 minutes for children aged 10 and older.

FKC 20.03

The case worker and resource family establish procedures for:

a. how to notify the organization following each use of a physical intervention;
b. documentation of the incident; and
c. debriefing with the child and resource family members involved in or witness to the incident.

Interpretation: *Debriefing should include:*

1. *the physical and emotional state of everyone involved;*
2. *precipitating events; and*
3. *how the incident was handled and any additional supports or resources needed in order to avoid future incidents.*

Interpretation: *Organizations that provide family foster care home services only may not be involved in debriefing, but should demonstrate implementation of the standard by ensuring the resource family complies with established procedures and documenting incidents.*

FKC 20.04 (FP)

Resource parents are trained on the child's individualized behavior support and management plan at placement, and receive annual training and evaluation on permitted physical interventions, including:

a. when it is appropriate to use a physical intervention;
b. proper and safe use of interventions, including time limits for use;
c. understanding the experience of being placed in manual restraints;
d. assessing physical and mental status, including signs of physical distress;
e. response techniques to prevent and reduce injury;
f. assessing when to discontinue the physical intervention; and
g. negative effects that can result from misuse of restrictive interventions.

NA: By virtue of law or contract, the organization does not train resource families.

Interpretation: *To ensure competency, resource parents should receive a post-test and be observed in practice.*

FKC 21: Resource Family Development, Support, and Retention

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

The organization promotes resource family development and retention by collaborating with resource families to identify and provide the support needed to ensure that children receive safe, consistent, and nurturing care.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• A calendar or listing of peer support, recreational, or social activities	
*	• Procedures for referring individuals to services	
*	• Procedures for annual mutual reviews with non-kin resource families	
*	• Copy of tool(s) for annual mutual reviews with non-kin resource families	
*	• Copy of tool(s) for kinship caregiver assessments	

Site Visit Evidence

*
- Documentation of attendance at peer support opportunities
- Informational materials on community resources provided to resource parents, including any specific materials for kinship caregivers
- Community resource and referral list
- Aggregate resource family retention data for the previous 12 months

On-Site Activities

*
- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Resource parents

- Review resource parent records
- Review case records

FKC 21.01

The organization facilitates networking and mutual support among resource families by providing:

a. regular, inviting, and accessible opportunities for peer support; and
b. recreational and social activities.

Interpretation: *Kinship care programs should offer activities more regularly if these activities are a fundamental component of the services they offer kinship families, such as if recreational activities function as a form of respite for kinship caregivers.*

Examples: *Opportunities for support can include regular meetings in which resource parents can share concerns and discuss strategies for managing their role, and/or social events that bring resource families together and give them the chance to get to know each other better. Organizations can work with resource parents to determine how to make peer support opportunities more accessible such as by offering meals, transportation reimbursement, or child care.*

Organizations can also offer tailored networking and support opportunities to meet the unique needs and interests of different groups of resource parents, for example, kinship caregivers, treatment parents, resource families caring for children with shared characteristics, resource parents who are LGBTQ, and prospective resource parents awaiting their first placement.

FKC 21.02

Resource families receive assistance to identify and access any services needed to improve family functioning and prevent and reduce stress and family crisis including:

a. child care;
b. counseling, including any services and supports needed to address family relationships;
c. respite care;
d. transportation;
e. peer support opportunities outside of the organization;
f. cultural, recreational, and social activities outside of the organization; and.
g. informal resources that can offer support.

Interpretation: *Regarding element (c), respite care options should be reviewed with resource parents prior to a child joining the family, and on a regular basis.*

Examples: *Informal resources that can offer support include: extended family, friends, and neighbors; members of clan, tribal, religious, and spiritual communities; local businesses or other community agencies; and other resource parents. As appropriate to each family's situation and in line with requirements for ensuring safety, the family and resource family can collaboratively or individually identify informal resources to help care for children and/or provide other types of support. This type of support may be included in service plans to ensure appropriate communication.*

FKC 21.03

Resource families participate in an annual mutual review to identify areas of strength and concern and develop plans for needed support and training.

NA: The organization provides kinship care services only.

Interpretation: *Kinship caregivers are not required to participate in the mutual review, and this standard will not be applicable when a resource family has not yet been matched with a child.*

Interpretation: *The annual re-assessment conducted as part of the home recertification process can be used to demonstrate implementation of this standard. However, the mutual review should not be conducted by a licensing worker as an isolated occurrence - in contrast, it should ideally be conducted in collaboration with the child welfare caseworker and include a review of information and issues that arose throughout the year.*

FKC 21.04

Kinship caregivers participate in an assessment of strengths and needs, and are helped to obtain any needed services and supports, related to the following areas:

a. financial assistance, including any specialized financial supports available to kinship caregivers;
b. legal services;
c. housing assistance and resources needed to provide a safe home environment;
d. food and clothing;
e. physical and mental health care;
f. training on child-specific needs to support them in their caregiving role; and
g. supportive services, including in-home and peer supports.

NA: By virtue of contract, the organization does not work with kinship caregivers.

Interpretation: *The assessment of strengths and needs should include attention to kinship caregivers' satisfaction and recommendations, as well as any discrimination they may face in their role.*

Interpretation: *When the organization is working with American Indian and Alaska Native children and families, tribal representatives should be used as resources to help locate the most appropriate services for kinship caregivers.*

FKC 21.05

The organization promotes resource family retention by:

a. providing resource families who have not yet been matched with a child ongoing information and support while they wait;
b. conducting exit interviews with resource families who leave the organization to determine why they left; and
c. annually evaluating retention data to determine what strategies/practices work well, and what strategies/practices may need to be modified or eliminated.

NA: The organization provides kinship care services only.

Family Foster Care and Kinship Care

FKC 22: Respite Care

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

Respite care reduces caregiver stress, promotes the stability of placements, and ensures child safety and well-being.
Interpretation: *If care is going to continue for an indefinite period of time, the notice and placement preferences in the Indian Child Welfare Act may apply.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Respite care planning procedures	
*	• Respite model(s) including the number of children permitted in respite care homes	
*	• Respite caregiver assessment procedures	

Site Visit Evidence

*	• Contracts and service agreements with respite care providers, if applicable

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Respite caregivers
    4. Resource parents

- Review case records

FKC 22.01

The organization collaborates with resource families to develop a written respite care plan that is regularly reviewed, and addresses:

a. available respite care resources;
b. frequency and duration of respite care; and
c. approved respite caregivers.

Interpretation: *Respite care plans for children in treatment foster care should be developed as part of treatment planning and reviewed at least quarterly.*

Examples: *Respite care planning can include helping resource families to identify individuals within their own support network, or the child's network, to designate as approved respite caregivers.*

Respite care plans may also incorporate developmentally-appropriate normalcy activities, such as recreational activities or sleepovers.

FKC 22.02 (FP)

The organization approves respite care homes based on an assessment of the caregiver's capacity to meet the child's individualized needs, including:

a. respite duration;
b. the number and the needs of other children in the respite care home;
c. ability to respect and support the child's culture, race, religion, gender identity, and sexual orientation;
d. relationship to the child;
e. appropriate skills or training to provide therapeutic or medical care, when necessary; and
f. sleeping accommodations appropriate to the child's age, gender, and any special needs, when providing overnight respite.

Interpretation: *Regarding element (b), generally, the number of children in respite caregiver homes should not exceed five children total and also should not contain more than:*

1. *two children under age two;*
2. *four children over age 13; and*
3. *two children in treatment foster care.*

Exceptions may be made for short-term stays, or to support connections to siblings or kin, depending on the respite caregiver's capacity and experience, and the child's safety or treatment plan.

FKC 22.03

Respite caregivers:

a. are familiarized with the child's daily routines, preferred foods and activities, safety plan, and needed therapeutic or medical care;
b. provide enriching activities appropriate to the child's interests, age, development, physical abilities, interpersonal characteristics, culture, and special needs; and
c. work with resource parents to plan for children’s continued participation in any therapeutic, educational, or employment activities, when applicable.

Interpretation: *Organizations that do not provide respite care in their own resource family homes must ensure that relevant information about the child is communicated to the respite care program to ensure appropriate care, and monior the child's and resource family's satisfaction with the respite caregiver.*

FKC 22.04 (FP)

When respite care is provided in response to a crisis, the organization provides needed developmentally, culturally, and age-appropriate interventions to help children cope with trauma or stress associated with the crisis.
NA: The organization does not provide respite care in crisis situations.

FKC 22.05 (FP)

When children in respite care experience accidents, health problems, or changes in appearance or behavior, information is promptly recorded and reported to the resource parents and administration, and follow-up occurs, as needed.

FKC 22.06 (FP)

Respite caregivers return children only to the resource parents, or another person approved by the resource parents, and follow procedures for situations that pose a safety risk or when a child requires protection.
Examples: *Protocols may include directions on how to engage community resources such as law enforcement or cab companies when individuals pose a safety risk, such as when individuals are intoxicated by drugs or alcohol, mentally or physically unstable, or present another safety concern.*

Family Foster Care and Kinship Care

FKC 23: Case Closing and Aftercare

Children in Family Foster Care and Kinship Care live in safe, stable, nurturing, and often temporary family settings that best provide the continuity of care to preserve relationships, promote well-being, and ensure permanency.

The organization works with reunified families, youth who are transitioning to independence, adoptive families, and families with permanent legal guardianship to plan for case closing and develop aftercare plans.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- In a few instances, the organization terminated services inappropriately; or
- Active client participation occurs to a considerable extent; or
- A formal case closing evaluation is not consistently provided to the public authority per the requirements of the standard.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Services are frequently terminated inappropriately; or
- Aftercare planning is not initiated early enough to ensure orderly transitions; or
- A formal case closing summary and assessment is seldom provided to the public authority per the requirements of the standard; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Case closing procedures	
*	• Aftercare planning and follow-up procedures	

Site Visit Evidence

*	• Relevant portions of contract with public authority, as applicable

On-Site Activities

*	• Interviews may include:

1. Program director
2. Relevant personnel
3. Parents
4. Children and youth

- Review case records

FKC 23.01

Planning for case closing:

a. is a clearly defined process that includes assignment of staff responsibility;
b. begins at initial assessment; and
c. involves the worker, children, families, resource families, and other supportive people chosen by children and families, as appropriate.

Examples: *Supportive people chosen by children and families can include, for example, extended family, friends, and other service providers.*

FKC 23.02

Upon case closing, the organization notifies any collaborating service providers, including the courts and tribal governments, as appropriate.

FKC 23.03

When children have been reunified with their families, the case closing process includes discussion with the family about the successful changes in behaviors and conditions that reduced risk to the child, and strategies for maintaining those changes.
NA: The organization, by virtue of law or contract, does not serve parents.

FKC 23.04

The organization works with children and families to:

a. develop an aftercare plan, sufficiently in advance of case closing, that identifies the family's needs and goals and facilitates the initiation or continuation of needed supports and services, including crisis resources; or
b. conduct a formal case closing evaluation, including an assessment of unmet need, when the organization has a contract with a public authority that does not include aftercare planning or follow-up.

FKC 23.05

The organization follows up on the aftercare plan, as appropriate, when possible, and with the permission of children and families.
NA: The organization has a contract with a public authority that prohibits or does not include aftercare planning or follow-up.