OVERVIEW

Payments for the care of a child in a placement from child care fund (CCF), state ward board and care (SWBC), title IV-E, limited term/emergency foster care/general, and Unaccompanied Refugee Minor (URM) fund sources are generated through service authorizations that are routed, approved, and amended in the electronic case management system. For age appropriate rates see FOM 905-3, Foster Care Rates.

The rate paid to the placement agency foster care (PAFC) provider for maintenance, clothing allowance, and any determination of care (DOC) must be paid by the PAFC provider to the caregivers providing the care.

WHEN A CAREGIVER MOVES

When the supervising agency is notified that a foster parent/relative caregiver is moving and wants to continue as a foster parent/relative placement, a referral must be made immediately, by the case manager, requesting the provider's new address be licensed/approved. The referral for a licensed provider is made to their licensing case manager. For unlicensed relative caregivers, the foster care case manager must approve the relative's new home; see FOM 722-03B, Relative Engagement and Placement.

Foster parents and relative caregivers must complete their address change in SIGMA Vendor Self Service (VSS) to continue to receive foster care payments. Payments to relative caregivers may continue as scheduled while the new home is assessed. There could be a change in fund source if there is a gap in dates the relative is approved. Licensed unrelated foster parents may have a gap in payments while the new address is licensed. Payments will be received once the new home is approved.

Caregivers Moving to Another State

If a foster parent or relative caregiver moves to another state, there are additional requirements to license or approve their new address. Licensed unrelated foster parents will experience an extended gap in foster care payments until the new out-of-state address is licensed, and payments will not be made while the unrelated foster parent is not licensed.

Note: There should not be a gap in payments for relatives because their payments are not related to the license.

MAINTENANCE RATE FOR FOSTER CARE

The maintenance rate refers to the scheduled rate paid for a child who requires no extraordinary care in relation to age other than what would be determined to be routine care and supervision of a child that has never experienced an out-of-home placement based on child abuse and/or neglect.

The maintenance rate was established based on the United States Department of Agriculture (USDA) study of the average cost of raising a child in the Midwest for a low-income family. The payment is a reimbursement, not a wage or salary, to cover ongoing, routine, and normally expected costs including:

- Room and board, food, personal care, routine transportation, and over-the-counter medical supplies not available through Medicaid. This is considered the room and board portion of the maintenance rate.
- Out-of-pocket expenses such as magazines, books, recreation, gifts, contributions, expendable school supplies, etc. are the allowance and personal incidentals portion of the maintenance rate. The exact determination of how much the allowance is and on what basis the caregiver provides it to the child is a matter for joint family and case manager determination.
- The portion of the maintenance rate intended for clothing is for incidental clothing needs through the year. More details regarding additional clothing allowance payments can be found in FOM 903-09, Case Service Payments.

Details regarding additional available case service payments can be found in FOM 903-09, Case Service Payments.

DETERMINATION OF CARE SUPPLEMENTS FOR FOSTER CARE

Children in out-of-home placement oftentimes require additional assistance above what is determined to be routine care and

supervision of a child that has never experienced an out-of-home placement. Determination of care (DOC) forms are to be completed **with** active involvement of the caregiver who is eligible for a foster care payment. **The DOC form must be completed for each child and is not contingent on a request being received from a provider. DOC rates are *in addition* to the daily foster care maintenance rates. The foster care daily maintenance rates cannot be negotiated.** Caregivers providing additional care and supervision to meet the needs of a child are eligible for a DOC rate, if they are eligible to receive foster care payments. A DOC may be justified based on the child's needs and not solely the actions of the caregivers. Timely completion of the DOC forms and ensuring the caregivers are paid the appropriate rate is an important task of the case manager.

The case manager is required to complete a DOC for all children receiving Supplemental Security Income (SSI). When a child qualifies for a DOC supplement due to a disability or specific medical or mental health diagnosis, the case manager must screen the child for SSI eligibility; see FOM 902-12, Government and Other Benefits.

Children receiving the additional rate for the serious emotional disturbance waiver (SEDW), or treatment foster care are not eligible for a DOC. For additional information on SEDW and treatment foster care; see *Waiver for Children with Serious Emotional Disturbance* in FOM 802, Mental Health, Behavioral and Developmental Needs of Children Under the Supervision of MDHHS.

Note: The caregiver and the case manager may not agree on what DOC level should be requested based on the assessment on the completed DOC form. **The caregiver's request must be submitted**. The case manager may add comments to the DOC form if they do not agree with the assessment and list the reasons why.

A DOC assessment must be completed in the electronic case record at the following points during a child's case:

- Within 30 calendar days of the child's removal.
- Within six months of the previously approved DOC.
- Within 30 calendar days of identifying the child's needs have changed.

- Within 30 calendar days of a placement change to a different foster parent or approved relative caregiver.

Completion of the DOC assessments apply to all caregivers eligible for payment, regardless of the fund source. In all case situations, the case manager must involve the caregiver in completion of the form and the caregiver must sign the assessment form. Each signed DOC assessment must be uploaded into the electronic case record. The caregiver must also be provided with a copy of the DOC assessment once it has been signed by all applicable individuals. The DOC assessment contains the information regarding the caregiver's right to an appeal if they do not agree with the approved DOC.

DOC rates are **not** to be authorized for any period that exceeds six months. If a DOC supplement continues to be necessary at the end of the authorized period, a new assessment must be completed, appropriate approval obtained, and the payment authorization completed.

When assessing the potential eligibility and continuation of a DOC supplement, complete the DOC form that most closely fits the case situation:

- DHS-470, Assessment for Determination of Care for Children in Foster Care (Age one day - 12 years).
- DHS-470A, Assessment for Determination of Care for Children in Foster Care (Age 13 and over).
- DHS-1945, Assessment for Determination of Care for Medically Fragile Children in Foster Care.

The individual activities required by the caregiver to meet the specific individual needs of the child placed in their home must be documented under the caregiver activities section of the parent agency treatment plan (PATP); see FOM 722-08D, Treatment Plans.

The ongoing activities to address the child's needs must be documented throughout the service plan, where applicable. This requirement does not mean that a DOC is to be denied until the updates have been made to service plans. The expectation is that the information will be included in the subsequent service plans.

The DOC must **not** include activities provided by a third party (person) for child day care, nursing care, respite care, assisted care, etc.

DOC Documentation

The PATP should reflect the caregiver activities presented in the DOC request form. The DOC request form is a separate document; activities may be verified through discussions with the child, caregivers, school, and/or therapist which would then also be documented in the PATP. Reviewing of social work contacts, therapy reports, and other school and/or medical documents contained in the electronic case record is not required for Levels I-III. **Submission of documentation beyond what is already maintained in the electronic case record is only required for a level IV DOC rate**.

Example: The caregiver, therapist, or the child report the caregiver participates in therapy with the child weekly. A letter from the therapist documenting the caregiver's involvement **is not required** solely for the approval of the DOC.

Example: The caregiver reports they are collaborating with the school. The detail regarding their involvement is documented in the child's service plan. Additional documentation from the school may be included in the child's electronic case record but **is not required** solely for the approval of the DOC.

Example: The caregiver discusses the child's behavioral needs at monthly home visits. While the caregiver may be completing behavior charts for the therapist or school, the submission of behavior charts **are not required** solely for the approval of the DOC.

A copy of the approved DOC form must be sent to the caregiver **and** the PAFC provider if applicable.

Begin/Effective Date of Request

The begin/effective date should reflect the appropriate date for the DOC payment.

The begin/effective date for an initial DOC is the date of placement. Within the first 30 calendar days of the placement, the MDHHS case manager must submit the completed DOC to their supervisor. PAFC supervisors must submit the completed DOC to the MDHHS

purchase of service (POS) monitor within the first 30 calendar days of placement.

The begin/effective date for a DOC renewal is the date following the end date of the last approved DOC. There must not be a gap between the DOC approvals. MDHHS case managers must submit the completed DOC to their supervisor at least 30 calendar days before the end date of the previously approved DOC. PAFC supervisors must submit the completed DOC to the MDHHS POS monitor at least 30 calendar days before the end date of the previously approved DOC.

The begin/effective date for an escalation or de-escalation of the DOC, prior to the renewal date, is the date the change in circumstance occurred. MDHHS case managers must submit the completed DOC to their supervisor within 30 calendar days of the change in circumstances. PAFC supervisors must submit the completed DOC to the MDHHS POS monitor within 30 calendar days of the change in circumstances.

When a change in the DOC level is approved, the DOC rate is retroactive to the begin/effective date on the DOC form.

If the case manager does not complete these steps timely, this does not negatively impact the payment to the caregiver. If there is a delay, an explanation must be provided.

Note: The caregiver, PAFC, or MDHHS case manager may initiate an administrative review if not notified timely of the DOC decision. An administrative review will be initiated for any DOC decision not received within 45 calendar days from the begin/effective date of the DOC request; see *Administrative Review Process*.

Duration of the DOC

When completing the DOC and it is known that caregiver involvement is not expected to last 180 days, the end date can be approved for less than the full 180 day maximum. No DOC may be approved for longer than 180 days.

For a child with an approved DOC, a de-escalation should be discussed with the caregiver at length to ensure the child does not meet other criteria to maintain the approved level. A DOC de-escalation must not be pursued if the caregiver activities in a

certain area are being discontinued for a short, pre-determined period.

Example: A DOC supplement is approved with an begin/effective date of April 1 with some school activities included in the DOC assessment. The DOC should not be ended for the summer or other school breaks.

Caregiver Approval of Rate

All completed/approved DOC forms must be provided to the caregiver. The case manager must complete the DHS-668, Notification of Determination of Care (DOC) Decision, with the caregiver within 30 calendar days of the DOC decision. The DHS-668 must be uploaded into the electronic case record along with the signed DOC.

Administrative Review

If the caregiver disagrees with the DOC determination or is not notified of a decision in a timely manner, the caregiver has a right to an administrative review. The administrative review must be initiated within 10 business days of the DHS-668 signature date.

For PAFC supervised cases, the agency must initiate the request for the administrative review on behalf of the caregiver. The request must be submitted even if the PAFC provider agrees with the MDHHS decision.

Administrative review decisions by the Federal Compliance Division (FCD) regarding DOC requests up to and including level III are final. Once an FCD decision is received, the local MDHHS office must implement any change in the DOC rate, as determined by FCD.

The county and/or business service center (BSC) director's decision on a level IV DOC is final and not eligible for the administrative review process.

PAFC Supervised Cases

If the caregiver signs the DHS-668, Notification of Determination of Care (DOC) Decision, requesting an administrative review, the following steps are to be taken:

1. The PAFC supervisor requests an administrative review on behalf of the caregiver by submitting the DHS-668, Notification of Determination of Care (DOC) Decision, to the MDHHS POS monitor's supervisor. This request must be sent within five business days of receipt/request by the caregiver.

2. The local MDHHS office has 10 business days from receipt of the DHS-668 to review the DOC assessment and complete the DHS-669. If, after review, the local MDHHS office agrees with the caregiver, the local MDHHS office must authorize all necessary changes to the assessment and payments. No further administrative review action is necessary. A new DHS-668 is required to reflect the approved rate.

3. If the local MDHHS office agrees with the original assessment the local MDHHS POS monitor's supervisor must forward the DOC assessment, DHS-668, and DHS-669 to FCD (mdhhs-federalcompliancedivision@michigan.gov).

4. FCD has 10 business days to review the administrative request from the local MDHHS office. FCD will notify the agency and local MDHHS director of the decision using the DHS-670, Federal Compliance Division (FCD) Decision to Administrative Review Request for Determination of Care (DOC) Denial.

5. Once an FCD decision is received, the local MDHHS office must implement any change in the DOC rate, as determined by FCD.

MDHHS Supervised Cases

If the caregiver signs the DHS-668 requesting an administrative review, complete the following:

1. The MDHHS case manager submits the DHS-668 to their supervisor.

2. The local MDHHS office has 10 business days from receipt of the DHS-668 to review the DOC assessment and complete the DHS-669, Local MDHHS Response to Administrative Review Request for Determination of Care Denial. If, after review, the local MDHHS office agrees with the caregiver, the local MDHHS office must authorize all necessary changes to the assessment and payments. No further administrative review action is necessary. A new DHS-668, Notification of

Determination of Care (DOC) Decision, is required to reflect the approved rate.

3. If the local MDHHS office agrees with the original assessment, the local MDHHS case manager's supervisor must forward the DOC assessment, DHS-668, and DHS-669 to FCD (mdhhs-federalcompliancedivision@michigan.gov).

4. FCD has 10 business days to review the administrative request from the local MDHHS office. FCD will notify the agency and local MDHHS director of the decision using the DHS-670, Federal Compliance Division (FCD) Decision to Administrative Review Request for Determination of Care (DOC) Denial.

5. Once an FCD decision is received, the local MDHHS office must implement any change in the DOC rate, as determined by FCD.

DOC-Level IV

If the child's DOC level exceeds level III on the DHS-470, Assessment for Determination of Care for Children in Foster Care (Age one day - 12 years), DHS-470A, Assessment for Determination of Care for Children in Foster Care (Age 13 and over), or DHS-1945, Assessment for Determination of Care for Medically Fragile Children in Foster Care, the caregiver and supervising agency/MDHHS may request an exception for a level IV child specific DOC supplement, which is a negotiated rate. To ensure timely, accurate, and appropriate utilization of all level IV DOC requests, the requirements/special handling below must be followed.

DOC Level IV Request Requirements

A negotiated DOC level IV does not require an additional memo for approval if the body of the DOC includes narrative justification to support the proposed DOC rate, including a statement of affirmation the proposed rate is believed to reduce the likelihood the child/youth will be escalated to a more restrictive setting (i.e., residential care). The DOC form **must** be completed and signed.

The proposed negotiated rate must be approved by the following:

- Primary case manager.
- Supervisor.

- County director.

If the negotiated DOC rate requested is greater than $150 per day, BSC director approval is also required.

The approved request must be routed through the electronic case management system to FCD. FCD will review the request for completeness, document the exception, and provide instruction to the case manager and supervisor as needed to process payment authorization in the electronic case management system.

The request must include a description of any other services and payments being provided for the child's care, including but not limited to assisted care, nursing services, day care, etc. Activities completed by another person cannot be included in the DOC assessment.

Example: An assisted care provider is in the home for eight hours per day to assist with feeding. The caregiver cannot also claim the same eight hours of feeding assistance.

Copies of the documentation supporting the DOC supplement must be scanned into the electronic case record and attached to the DOC task within the service authorization and in the child's case record.

Documentation may include any of the following:

- Hospital/medical records/doctor's statement(s).
- Psychiatric evaluation.
- Psychological evaluation.
- Case service plans.
- Foster care provider logs.
- School records/evaluations/individual education plan.
- Institutional discharge summaries.

Following the BSC director's approval, the request must be routed by either the MDHHS local office or BSC**,** to FCD to process payments.

Note: Reauthorization requests for a level IV DOC must be submitted 30 calendar days before of the expiration of the prior authorization to ensure adequate review time.

WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

Community Mental Health (CMH) determines eligibility and approval for the SEDW. Caregivers receiving foster care payments for a child receiving SEDW services are eligible for an elevated SEDW daily rate in addition to the foster care daily rate. The SEDW rate is only applicable to caregivers receiving foster care payments.

Note: A DOC IV may be utilized in lieu of an SEDW daily rate if appropriate.

Total Daily Rate With SEDW

Age Group	SEDW Daily Rate	Daily Maintenance Rate	Total Daily Rate for Youth Receiving SEDW
0 - 12	$32.76	$22.35	$55.11
13 - 18	$29.41	$26.69	$56.10

Once the local MDHHS office receives notification from the Waiver Support Application (WSA) of the child's eligibility for the SEDW, the case manager must complete the following steps:

- Complete the DHS-1254, SED Waiver Payment Request and Approval, and obtain appropriate signatures. The behavioral health analyst signature will be completed at the time of approval.
- Complete the SEDW payment authorization in the electronic case management system. The case manager must upload the completed DHS-1254 and approval documentation into the electronic case record.

- Route the SEDW payment authorization to the behavioral health analyst in the Child Welfare Medical and Behavioral Health Division for approval. The behavioral health analyst will sign and upload the DHS-1254, approve, and route the SEDW payment authorization to FCD for final approval.

Note: Children receiving the additional rate for the SEDW are not eligible for a DOC or a treatment foster care rate; see SEDW job aid for further instructions.

TREATMENT FOSTER HOMES

Treatment foster homes are provided in limited counties by specific providers. Treatment foster home placements must be approved by the MDHHS supervisor.

Treatment foster home placements have a standard daily maintenance rate of $75. The approval for treatment foster care placement is requested through the placement exception request screens in the electronic case management system. For placements 12 months or longer, an approved DHS-974, Treatment Foster Care Extension Request, must also be uploaded to the placement service authorization.

Note: Children receiving the additional rate for treatment foster care are not eligible for a DOC or SEDW rate.

TRANSITIONAL PLACEMENT PROGRAM

The transitional placement program (TPP) provides shelter homes for emergency short-term placement. These homes are managed by local county offices and are contracted through MDHHS. TPP homes have a daily rate of $106 in addition to the standard daily rate. Placement in TPP homes must be approved by the county director. The processing of these contracts is the responsibility of the Bureau of Grants and Purchasing (BGP); see FOM 944, Family Shelter Home: Forms and Procedures. Children receiving the additional rate for TPP are not eligible for a SEDW rate but are eligible for a DOC.

PAYMENT POLICY FOR FOSTER CARE YOUTH WITH CHILDREN IN THE SAME PLACEMENT

Children of foster care youth who are placed in the same foster care setting as their youth parent are entered into the electronic case record differently based on the court involvement.

Scenario 1: Both parent and child are in foster care. A signed court order exists removing the child from the youth parent and MDHHS is responsible for the child's placement and care.

- Regardless of the child's placement, an initial funding determination must be completed to assess the child's title IV-E eligibility independent from their youth parent.
- The child's placement is entered as the actual placement even if the child is placed in the same home as the child's youth parent.
- The child's placement is not entered as a parental home placement unless the court has ordered the reunification.
- The child will have their own service authorization and payment history.
- The ward child add on is not used in the electronic case record.
- If the child's case is managed by a PAFC, the administrative rate is paid through the child's service authorization.

Scenario 2: Only the parent is in foster care. A signed court order does not exist removing the child from the youth parent and the child remains in the care of their parent and MDHHS is not responsible for the child's placement and care.

- The child does not have an independent initial funding determination because they are not removed from their youth parent.
- The child does not have their own case in the electronic case management system.

- The child's payment is entered as a ward child add on to the youth parent's service authorization. This allows the caregiver to receive an additional payment for the child.
- No administrative payments are made to the PAFC for the child since they do not have an independent court case.
- If the youth parent moves to another placement that is not appropriate for the child or is absent without making prior arrangements for their child, centralized intake (CI) must be contacted. The child cannot remain in a foster home without prior arrangements with the youth parent or a court order authorizing the child's removal. MDHHS does not have any legal authority to place or make decisions for the child without a court order.
- **Example 1:** The youth parent goes to the hospital for a few days and planned with all parties for the child to stay with the caregiver. No further contacts need to be made and the caregiver continues to receive payment through the bed hold process for the youth parent.
- **Example 2:** The youth parent leaves the home without the child and does not return as expected. The child cannot remain at the foster home while the youth parent is absent without legal permission (AWOLP) without a court order. No arrangements were made prior to the youth parent's departure and CI must be contacted to further investigate.
- If the child is later removed through a court order, follow *scenario 1* above. The child should have their own case established in the electronic case management system.

Case Service Payments

Children of youth parents are eligible for case service payments. If the child is being paid through the ward child add on process, the case service must be authorized using the youth parent's information in the electronic case record; see FOM 903-09, Case Service Payments.

Holiday Allowance

A holiday allowance is not auto generated for a child being paid through the ward child add on process. This must be added as a case service and manual payment.

Clothing Allowance

The semiannual clothing allowance for the youth parent's child is done automatically and is payable to the caregiver or agency if appropriate.

If an initial clothing allowance is necessary, a case service authorization for the initial clothing allowance can also be requested in the electronic case management system. For a child being paid through the ward child add on process, the case service authorization for the initial clothing allowance is to be issued in the youth parent's name with the notation in the comments section this is the initial clothing allowance for the child of the youth parent.

Note: No DOC is paid for the youth parent's child who is being paid through the ward child add on process. A child's maintenance rate is included for each child. A Family Independence Program (FIP) grant for the child's personal needs cannot also be established.

Child's Medical Assistance Eligibility

It is necessary to establish a medical assistance (MA) case for the youth parent's child(ren) who are being paid through the ward child add on process. Bridges Eligibility Manual (BEM) 145, Newborns, states that a newborn is automatically eligible for MA the month of birth if, for newborn's date of birth, newborn's mother receives Medicaid coverage, regardless of when that coverage is authorized.

Eligibility continues through the month of the newborn's first birthday if the newborn meets the MA eligibility factors in all the following items:

- BEM 220, Residence.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.

A newborn who meets the above criteria is eligible for MA. The case manager must assist the youth parent with ensuring the newborn has MA established. This may be done at the hospital or at the local MDHHS office.

Child Care Services

If the foster youth parent is in school or employed and the caregiver is not providing the child care services for the child(ren), payment for child care may be available through the department's child care services program. The foster youth parent must first complete the application process for the child care services program at the MDHHS local office and meet the eligibility criteria. If the youth parent is not eligible, youth in transition (YIT) is a secondary option.

If the child is placed directly with the caregiver, the caregiver must apply for child care services as needed.

Independent Living for Youth Aged 18 or Older with Children

Independent living (IL) payments cannot be authorized to the youth parent if they are receiving FIP assistance for themselves. If a youth parent, age 18 or older, and the youth's child(ren) are living independently or with an adult who has no supervisory responsibility for the youth parent, the youth parent may apply for a FIP grant for the youth's child(ren). If the electronic case management system shows an error and will not allow FIP and IL payments in the same month, route the placement service authorization to FCD in the electronic case record.

Minor Parents

IL payments cannot be authorized to the youth parent if they are receiving FIP assistance for themselves. This applies to youth parents under the age of 18 with dependent children in their care; see BEM 201, Minor Parents. If the youth parent and the youth's child(ren) are not living in a licensed foster care placement, they must reside in an adult supervised setting to qualify for FIP. The youth parent may apply for a FIP grant for their child(ren). If the electronic case management system shows an error and will not allow FIP and IL payments in the same month, route the placement service authorization to FCD in the electronic case record. IL youth

do not receive the ward child payment unless they are in young adult voluntary foster care (YAVFC).

POLICY CONTACT

Any questions about making these payments from the electronic case management system can be directed to FCD (MDHHS-federalcompliancedivision@michigan.gov).