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|  | **PROFESSIONAL SERVICES REFERRAL** This authorization is valid for up to 180 days from the date of this referral | DATE OF REFERRAL |

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| Starting Date |  | Ending Date  (Max 3 month for counseling & 6 month for evaluations) |  |
| Provider Name |  | FAMLINK Provider ID # |  |
| DCYF Caseworker |  | DCYF Caseworker Phone # |  |
| DCYF Office |  | FAMLINK Case ID # |  |
| Client’s Name  (For Children also give caregiver’s name) |  | Client Phone #  *(For children also give the caregiver’s phone number )* |  |

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| **Alternatives Explored**  If the client can obtain an equivalent service through any of the entities listed below, then those must be used prior to referring for DCYF contracted services. | |
| Counseling & Evaluation | Health Care Authority (HCA), Medicaid (aka Washington Apple Health),  Managed Care Organization (MCO) (i.e. Apple Health Core Connections) or Behavioral Health Administrative Service Organization (BH-ASO),  Private insurance,  Developmental Disabilities Administration  School District Special Education  Early Support for Infants and Toddlers (ESIT)  Division of Vocational Rehabilitation  Other |
| Explain if OTHER is chosen above |  |

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| **Service Requested**   * *If DCYF is paying for an evaluation or a specific month of counseling, providers cannot accept other funding.* * *The provider must have a current Professional Services contract with DCYF in order to provide the services below.*   *Rates must be as agreed upon in the contract for reimbursement. Allowed hours & rates are posted at:* <https://www.dcyf.wa.gov/services/child-welfare-providers/contracted-services> | | **Maximum Hours** | **Hours Authorized** |
|  | **Chemical Dependency Assessment & Treatment** | [See link](https://dcyf.wa.gov/sites/default/files/pdf/fee_SUD.pdf) |  |
|  | **Counseling, Therapy, Crisis Response or Treatment with Intake Assessment**  Session Format:  Individual  Family (2 or more people in same home or family)  Internal DCYF Staff  Group (unrelated individuals) | **20**hrs within a **3** month period (**20hrs/3month**)  Or  As specific in approved contract |  |
|  | **Evidence Based Practices (EBP) with Intake Assessment**  Session Format:  Individual  Family (2 or more people in same home or family)  Approved EBPs:  Cognitive Behavioral Therapy (CBT)  Dialectical Behavioral Therapy (DBT)  Trauma Focused Cognitive Behavioral Therapy (TF-CBT)  Alternatives for Families Cognitive Behavioral Therapy (AF-CBT) | **Defined by each EBP model, not to exceed 6 hours per month, and 6 months of services** |  |
|  | **Developmental Assessment** | **10hrs** |  |
|  | **Domestic Violence Evaluation** | **5hrs** |  |
|  | **Domestic Violence Treatment** | **20hrs/3month** |  |
|  | **Parenting Assessment** | **10hrs** |  |
|  | **Parenting Instruction**  (Group Parenting Instruction only) | **15hrs/3month** |  |
|  | **Adult Sex Offender Treatment** | **15hrs/3month** |  |
|  | **Sexual Deviancy Evaluation (**Adults only)  Also administer a:  Polygraph  Plethysmograph | **10hrs** |  |

**\*\*\*\* PRESENTING ISSUES & TREATMENT GOALS FOR CLIENT ON NEXT PAGE \*\*\*\***

**Identified Client** (name):

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| **Presenting Issues & Treatment Goals**  *DCYF staff referring a client for services must clearly articulate the need for this service as it relates to child safety and/or well-being, and the permanency planning goals of the case. If details including specific questions or topic to be addressed in the evaluation or counseling sessions are provided here, a separate referral letter to the provider is unnecessary.* |
| ***Presenting Issues*** |

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| ***Goals*** *for Counseling or Treatment* |

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| **Supporting Documentation**  *Referring DCYF staff must attach all relevant information needed to assist the provider in the evaluation or treatment of the client. Check the boxes next to the attachments that accompany this referral.* |
| Intake/Referral  Investigative Assessment  Psychological Evaluation  Court Report  Visitation Reports  Parenting Assessment  Medical Records  Substance Use Disorder Evaluation  Other: |

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| Social Worker Signature |  | Print Name |  | Date |
|  |  |  |  |  |
| Supervisor Signature |  | Print Name |  | Date |
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| Area Administrator Signature |  | Print Name |  | Date |
|  |  |  |  |  |
| Appointing Authority |  | Print Name |  | Date |
|  |  |  |  |  |

**ADDITIONAL APPROVAL REQUIRED**: If there are exceptional circumstances which justify exceeding the allowed hours on the Published Fee Table, or if counseling / treatment must extend beyond the initial 3-month referral, then the Area Administrator must also approve this referral. Counseling extensions may only be authorized after careful review of the case, evaluation of progress on treatment goals, and a demonstrated need for continued service in order to support child safety, permanency and well-being.

**Professional Services Quick Reference Guide for DCYF Workers**

The Published Fee Table with the rates & allowed hours is posted at <https://www.dcyf.wa.gov/services/child-welfare-providers/contracted-services>

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| **Service** | **Description** | **Published allowed service hours** |
| **Chemical Dependency Assessment & Treatment** | An assessment or treatment by a provider who is certified to provide this service in the State of Washington. The written assessment report must meet the general standards below. Inpatient or outpatient treatment will be provided according to the contract terms and recognized standards in the field of substance use disorder. | DCYF should be the payee of last resort after Medicaid, the Parents in Reunification Program, or other resources.  **One evaluation per a client.** Paid per completed evaluation.  **Treatment**: As recommended in the evaluation, if approved by DCYF, and paid per Published Fee Table |
| **Counseling, Therapy, & Treatment** | Therapist will provide counseling, therapy, crisis response treatment or treatment services, using evidence based, promising practice, or other recognized therapeutic techniques to assist an individual or a family in the amelioration or adjustment of mental, emotional or behavior problems.  Internal staff professional service referral will be send to Assistant Secretary or designee  If the court orders the DCYF to pay for the treatment of adult sex offenders, then that will be authorized under this heading. (See [Published Fee Table](https://www.dcyf.wa.gov/services/child-welfare-providers/contracted-services)) | Maximum of **20 hours within a three (3) month period** per family, or for a person participating in individual or group treatment.  Authorizations are valid for **3 months.** Any subsequent referrals require approval by the AA or Appointing Authority |
| **Evidence Based Practices (EBP)** | Therapist will provide DCYF approved EBP including individual and/or family counseling, therapy or treatment services while following all model fidelity requirements.  List of approved EBPs include:   * Cognitive Behavioral Therapy (CBT) * Dialectical Behavioral Therapy (DBT) * Trauma Focused Cognitive Behavioral Therapy (TF-CBT) * Alternatives for Families Cognitive Behavioral Therapy (AF-CBT)   A written intake assessment report must be submitted to DCYF within 30 days from the time of the initial intake appointment. | Defined by each EBP model, not to exceed 6 hours per month and 6 months of service |
| **Developmental Assessment** | The Contractor shall provide a written assessment of the client’s cognitive, emotional, physical, behavioral, academic and/or social characteristics and patterns of disorder. The Contractor also shall evaluate the client’s prognosis and amenability to treatment based on direct examination and interview, appropriate testing, collateral contacts and/or records review. | **10 hours maximum** per assessment  (includes written report) |
| **Domestic**  **Violence**  **Perpetrator**  **Assessment & Treatment** | A program that is certified by the State of Washington per WAC 110-60A and <https://app.leg.wa.gov/WAC/default.aspx?cite=110-60A>  The Contractor will conduct an individual and complete clinical intake and assessment interview with each perpetrator covering all of the topics required in the WAC. The Contractor will then develop and employ a written treatment plan for each individual, with a focus on treatment which will end the participant’s physical, sexual, psychological abuse of the participant’s victim(s). | DCYF is to be the payee of last resort: Contact Regional Program or Contracts Manager for further direction  DV Assessment **5 hours maximum** |
| **Parenting Assessment** | An assessment which includes direct examination and interview of the parent and all children referred, including a minimum of one hour observation of the parent/child interaction. The assessment also includes a review of family and parenting history, (including questions about abuse, neglect, DV, and substance abuse); an examination of the parent’s attachment to the children, parenting & discipline skills, and ability to seek services for the child’s needs; and collateral contacts or record review. The contractor must also administer standardized, reliable, & validated measures of parenting skills, parenting stresses, and potential for abusive behavior. | **10 hours maximum** per evaluation (includes written report) |
| **Parenting Instruction** | Provider will use a standardized curriculum that is approved by the DCYF Regional Program Manager to provide parenting instruction to the client in a group setting. No individual parenting instruction through this contract. | **Maximum of 15 hours within a three (3) month period** |
| **Sexual Deviancy Evaluation**  (ADULTS ONLY) | Contractor will provide a written sexual deviancy evaluation of the client’s emotional, social and behavioral characteristics, history and patterns of sexual deviance, prognosis, and amenability to treatment. The evaluation shall be based on direct examination and interviews, appropriate testing, collateral contact and/or records review.  These evaluations may also include a polygraph test to determine the client’s truthfulness in response to case specific questions, and/or a penile plethysmograph test to help determine sexual arousal patterns, if these are specifically approved in advance by DCFS. The contractor shall observe and interview the client and evaluate the results of the tests. The written report of this testing must include both the original document written by the test administrator, and an analysis by the contractor. | DCYF is to be the payee of last resort: Contact Regional Program or Contracts Manager for further direction  **10 hours maximum** per evaluation (includes written report)  Polygraph & Plethysmograph are paid separately  Treatment: See Published Fee Table |

**REPORTS:** All evaluation or assessment reports must include:

* The source and reason for the referral.
* Background information on the client.
* An account of the client’s view of their history & present situation.
* A description of the tests conducted & their results.
* The conclusion section of the report must include a diagnosis, information about prognosis & barriers, and specific & detailed recommendations for additional services (including an explanation of those recommendations).