Tennessee Department of Children's Services

Child and Family Team Meeting Summary

Meeting Date _____ Meeting Time: _____ Type of CFTM: _____

Location: _____ TennCare Appeal Rights Explained: ☐ Yes ☐ No

Confidentiality Agreement:
During the Child and Family Team Meeting we ask that all participants respect the family's privacy. Sensitive issues may be discussed and we want everyone to feel safe to express their opinions or voice their concerns. DCS has an obligation to keep information related to child abuse or neglect confidential from public disclosure. However, the confidentiality of information shared at a Child and Family Team Meeting cannot be guaranteed. There are circumstances when information discussed may be shared in order to make informed decisions about placement, services, treatment and/or permanency for child(ren). DCS must comply with the request of the court to supply information.

Please be advised that DCS is required to report any information related to:

- New allegations or suspicions of the abuse of neglect of a child
- If someone threatens to harm himself or herself
- If a direct threat is made against another party

We trust that all participants agree to safeguard the privacy of this family and what is discussed during the meeting.

☐ By checking this box, the facilitator indicates that they reviewed the Confidentiality Agreement with the team at the beginning of this meeting.

☐ By checking this box, the facilitator indicates that the participants agree the CFTM Summary may be shared with all team members, including those who may not be present at this meeting.

Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.

Distribution: Case File and Each CFTM Participant

CS-0747-1 Rev. 7/21)

RDA 11016

Participants	Role/Relationship to Child/Youth	Participation Method

Permanency Goal(s):

Child Concerning	Permanency Goal(s)	Status	Changed Y/N

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Family Story: What is the family saying about why we are here, what are their needs/strengths, what do they want to see happen?

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Diligent Search: Is there any new information available on absent/uninvolved parents, grandparents, adult relatives or significant kin at this time? What efforts have been made to locate, contact, or engage them?

Concurrent Planning: Was there a discussion about the appropriateness of adding a concurrent goal? If so, what was discussed?

Worker Observation(s)/Additional Information:

Educational Stability:

Did this meeting result in an entry into foster care or placement change? ☐ Yes ☐ No

If yes, a Best Interest Determination Meeting with the school system to ensure educational stability may be required. Please mark the checkbox that best explains the circumstances of this youth/ child.

☐ The new placement is within a one hour drive from the school the child/youth is currently enrolled. A Best Interest Determination (BID) Meeting with school personnel is required under guidance from the Every Student Succeeds Act to determine if it is in the best interest for the child/youth to remain in the school they are currently enrolled or transfer to the new school of zone. Who will notify the Education Specialist of the need for a BID Meeting? _____

☐ The new placement is over an hour drive from the current school and it is not feasible for the child/youth to remain in the school of origin. The child/youth will be enrolled in the new school immediately.

☐ The child/youth will attend school in a treatment facility and does not require a BID meeting regardless of the distance from the current school.

☐ There is a safety risk/concern/treatment need identified by the Child and Family Team that suggests it is not in the child/youth's best interest to remain in the school of origin. Consultation with the Education Specialist will occur to determine if a BID Meeting is needed based on those special circumstances. Who will consult with the Education Specialist? _____

☐ A new placement is needed for the child/youth, but one has not been identified at this time. Once the placement is identified, the assigned worker will determine next steps as outlined in the options above.

To create and support educational stability for children/youth in foster care when placement change occurs, the team should review, consider the assurances listed below. By marking the following checkboxes, the Child and Family Team assures:

☐ When determining placement, the team considered the appropriateness of the current educational setting and the proximity to the school the child/youth was enrolled at the time of placement.

☐ As indicated above, DCS will coordinate with the local education agency to ensure the child/youth can remain in the school of origin if it is in the child/youth's best interest. If it is not in the child/youth's best interest to remain in the school of origin, DCS will immediately enroll the child/youth into a new school with all of his or her available educational records.

Other information to consider when planning for educational stability for this child/youth:

_____

_____

_____

Strengths Discussed:

Person Concerning: _____

Strength Category: _____

Start Date: _____

Current Description

_____

_____

Person Concerning: _____

Strength Category: _____

Start Date: _____

Current Description

Strengths Discussed:

Person Concerning: _____

Strength Category: _____

Start Date: _____

Current Description

Person Concerning: _____

Strength Category: _____

Start Date: _____

Current Description

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Person Concerning: _____

Strength Category: _____

Start Date: _____

Current Description

Person Concerning: _____

Strength Category: _____

Start Date: _____

Current Description

Needs Discussed

Child and Family History of Trauma/Adverse Experiences:

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Child and Family Recent and/or Ongoing Trauma/Adverse Experiences:

Visitation Needs/Concerns

Person Concerning: _____

Need Category: _____

Start Date: _____

Current Description

Social, Medical & Educational Needs Addressed: ☐ Yes ☐ No

Independent Living/Transition Plan ☐ Yes ☐ No

Responsibilities	**Responsible Party**	**Start Date**	**End Date**

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Progress/Update Status:

Progress Description (what has changed)

Needs/Concerns+

Person Concerning: _____

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Need Category: _____

Start Date: _____

Current Description

Social, Medical & Educational Needs Addressed: ☐ Yes ☐ No

Independent Living/Transition Plan ☐ Yes ☐ No

Responsibilities	**Responsible Party**	**Start Date**	**End Date**

Progress/Update Status:

Progress Description (what has changed)

_____

_____

_____

_____

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Needs/Concerns

Person Concerning: _____

Need Category: _____

Start Date: _____

Current Description

Social, Medical & Educational Needs Addressed: ☐ Yes ☐ No

Independent Living/Transition Plan ☐ Yes ☐ No

Responsibilities	Responsible Party	Start Date	End Date

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Progress/Update Status:

Progress Description (what has changed)

_____

_____

_____

_____

_____

Needs/Concerns

Person Concerning: _____

Need Category: _____

Start Date: _____

Current Description

Social, Medical & Educational Needs Addressed: ☐ Yes ☐ No

Independent Living/Transition Plan ☐ Yes ☐ No

Responsibilities	Responsible Party	Start Date	End Date

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Progress/Update Status:

Progress Description (what has changed)

Needs/Concerns

Person Concerning: _____

Need Category: _____

Start Date: _____

Current Description

Social, Medical & Educational Needs Addressed: ☐ Yes ☐ No

Independent Living/Transition Plan ☐ Yes ☐ No

Responsibilities	Responsible Party	Start Date	End Date

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CS-0747-1 Rev. 7/21)

Progress/Update Status:

Progress Description (what has changed)

Needs/Concerns

Person Concerning: _____

Need Category: _____

Start Date: _____

Current Description

Social, Medical & Educational Needs Addressed: ☐ Yes ☐ No

Independent Living/Transition Plan ☐ Yes ☐ No

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Responsibilities	Responsible Party	Start Date	End Date

Progress/Update Status:

Progress Description (what has changed)

Next Meeting Date: _____ Time: _____

Family Members are encouraged to contact DCS at any time as needed for services, questions or concerns. You may contact your worker or their supervisor for assistance.

My Family Service Worker is _____ and his/her phone number is _____

Their Team Leader is _____ and his/her phone number is _____

Did Everyone Agree with the CFTM Decision? ☐ Yes ☐ No

If anyone disagrees with the CFTM Decision, please provide details:

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Signature Page for CFTM

By signing this document you acknowledge that you are a participant of this meeting. Your signature also indicates that you agree as a participant of this meeting to keep all information presented by the other participants of this meeting confidential, including but not limited to, the contents, purpose, or outcome of the meeting with anyone outside of the team. By signing this document you acknowledge that you understand the release of information regarding this case is prohibited by law, except in certain circumstances determined by DCS.

If a member of the team is unwilling to sign this document, please print their name on the signature page and note the refusal to sign in the disagreement portion of this document.

Name/Signature:	Relationship to Child/Family	I received TN Care Appeal Rights (Y or N)	I received an NOA (Y or N)

This signature is required if the CFTM resulted in a placement move to a Qualified Residential Treatment Program (QRTP). Due to the CANS actionable items and all other reasons discussed in this CFTM, the team is in agreement that this child's/youth's needs cannot be met in a foster home. A QRTP is the most appropriate placement to meet the needs of this child/youth.

Signature _____ **(COE Assessment Consultant/Third Party Reviewer)**

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GUIDE TO NEEDS AND STRENGTHS

Strength Categories:

Community Connections
Education
Employment
Family Bond
Family Safety
Financial Resources
Health Insurance
Home Maintenance
Independent Living Skills
Interpersonal Relationships
Involvement in Caregiver Functions
Job Functioning
Knowledge of Child and Family Needs
Mental Health
Natural Supports
Optimism
Other
Parental Permanency
Parenting Skills
Physical Health
Preparation for Adulthood
Relationship
Residential Stability
Resiliency
Social Functioning
Spiritual/Religious
Supervision
Support System
Talents/Interests
Transportation
Vocational

IL Strength Categories

Education
Employment
Financial Resources
Health Insurance
Maintenance
Independent Living Skills
Involvement in Caregiver Functions
Job Functioning
Knowledge of Child and Family Needs
Other
Mental Health
Parent/Parenting Skills
Physical Health
Preparation for Adulthood
Relationship
Residential Stability
Social Functioning
Social Support
Transportation
Vocational

GUIDE TO NEEDS AND STRENGTHS

Need Categories:

Assault
Attachment
Criminal Activity
Danger to Others
Delinquencies
Developmental Delays
Discipline
Domestic Violence
Education (**also IL**)
Emotional Abuse
Employment (**also IL**)
Family Conflict
Family Extended
Family Functioning
Financial Resources (**also IL**)
Fire Setting
Health Insurance (**also IL**)
Home Maintenance (**also IL**)
Immigration (**also IL**)
Independent Living Skills (**IL**)
Job Functioning (**also IL**)
Marital Conflict
Mental Health (**also IL**)
Neglect
Other Behaviors
Other Self-Harm
Parenting
Permanency
Physical Abuse
Physical Condition of Home
Physical Health (**also IL**)
Preparation for Adult Living (**IL**)
Relationship (**also IL**)
Residential Stability (**also IL**)
Resources
Restorative Justice
Runaway
Safety
Self-Mutilation
Sexual Abuse
Sexual Aggression
Sexual Offender
Sexually Reactive
Social Functioning (**also IL**)
Substance Use/Abuse
Suicide Risk
Support System (**also IL**)
Transportation (**also IL**)
Trauma
Vocational (**also IL**)

Tennessee Department of Children's Services

Notice of Action

Special Note to DCS Family Service Workers:
This Notice of Action (NOA) must be completed for each level of care change, higher or lower, for levels 2, 3, or 4 within 2 days of the Child and Family Team Meeting (CFTM)

Date NOA Completed: _____

Child's Name: _____ TFACTS ID: _____

DCS Region: _____ County of Custody: _____

Date of Custody: _____ FSW Name: _____

FSW Phone #: _____ Date of CFTM: _____

THIS NOTICE TELLS YOU ABOUT THE PLACEMENT DECISION DCS MADE AND WHAT YOU CAN DO IF YOU DISAGREE WITH THE DECISION OR HAVE TO WAIT FOR PLACEMENT.
FEDERAL LAW, 42 U.S.C.A. §672(a)(2)(B), and STATE LAW, T.C.A. §37-1-129(c)(1), GIVE DCS THE AUTHORITY TO DECIDE YOUR PLACEMENT BECAUSE YOU ARE IN DCS' LEGAL CUSTODY.
WE HAVE LOOKED AT WHAT YOU NEED AND MADE THE FOLLOWING DECISION:

New, Recommended Placement and level of care we think you need: _____ Start Date: _____

Previous Placement and Level of Care we think is no longer needed: _____

This placement will stop on: _____

Who made this decision? _____

Will there be a wait for the recommended placement? Yes ☐ No ☐ If yes, reason for delay:

_____

We expect the recommended placement to be provided in: ☐ 1 week ☐ 2 weeks ☐ 30 days

If there will be a delay, you will receive these services until the recommended placement can be made: _____

_____

_____

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What context was this decision made? (i.e. CFTM, legal consult, professional meeting, treatment team meeting, etc). _____

How was this new placlement decided? (check all that apply):

- ☐ Completion of Treatment Goals
- ☐ CPS Investigation
- ☐ Court Recommendations
- ☐ Emergency Health Care/Mobile Crisis
- ☐ Well-Being Information and History Form
- ☐ EPSDT Screening
- ☐ PCP Recommendations
- ☐ CFTM
- ☐ Mental Health Assessment (Psychological)
- ☐ DCS Assessments (CANS, etc.)
- ☐ Educational Assessment
- ☐ TEIS Evaluation
- ☐ COE Evaluation
- ☐ Disruption
- ☐ Runaway
- ☐ Hospitalization
- ☐ Administrative Issue at Current Placement
- ☐ Immediate Circumstances Require this Level of Care
- ☐ New Custody Child/Youth
- ☐ Other: _____

Reason for placement change. This is why we made this decision. (check all that apply):

- ☐ Initial medical/behavioral indicators require this level of care.
- ☐ CFTM recommends this level of care.
- ☐ Current Assessments indicate a higher/lower level of care is needed.
- ☐ Progress in treatment warrants a step down in level of service.
- ☐ Re-evaluation of treatment progress indicates higher level of care needed.
- ☐ Child's behavior requires an immediate change in placement.
- ☐ Completion of incarceration at YDC indicates a change of placement.
- ☐ Administrative circumstances require a change of placement.
- ☐ Judicial review/order received and placement determination made to address service needs.
- ☐ Special investigation requires change of placement.
- ☐ Other: _____

Who did we talk to when making this decision? (check all that apply):

- ☐ CFTM Members
- ☐ Placement Provider Staff
- ☐ Treating Provider
- ☐ Court
- ☐ PCP
- ☐ School
- ☐ DCS Consultants
- ☐ Foster Care Review Board
- ☐ CASA

☐ Child's Current Caregiver
☐ Child's Former Caregiver
☐ GAL
☐ Public Defender/Public Defender Staff
☐ Other: _____

What documents did we use to help us make this decision? (check all that apply):
☐ DCS Assessments (List:_____)
☐ External Assessments (List:_____)
☐ Discharge Summaries
☐ Progress Reports
☐ Court Documents
☐ School Records
☐ Other: _____

Did anyone at the CFTM say they want to appeal this placement decision? Yes ☐ No ☐

Who said they wanted to appeal? _____

THESE PERSONS GET A COPY OF THE NOTICE OF ACTION

INCLUDE NAMES, CURRENT ADDRESSES & ENSURE THAT THIS INDIVIDUAL IS ENTERED INTO TFACTS AND THE RELATIONSHIP HAS BEEN ESTABLISHED PRIOR TO GIVING TO PLACEMENT UNIT		**Attended CFTM?**	**Received NOA?**	**TennCare Appeal Form Given**
Youth (14 and over):		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
*Biological Mother:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
*Biological/Putative/Legal Father:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
*Adoptive Mother/Legal Caretaker:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
*Adoptive Father/Legal Caretaker::		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
**Other Involved Adult(s):		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
GAL:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Advocate:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Youth's attorney:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Foster Parent(s):		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DCS Contract Agency Provider:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

* If parental rights terminated, parents do not receive a copy of the NOA.
** At discretion of FSW, based on the person's involvement in making decisions about the child's care.

What to do if waiting this long is a problem for the child. You can appeal. Someone else will take a look at this. They can see if there is a way to get the care quicker if the child needs it quicker.

What to do if you think we are wrong. You can appeal. Someone else will take a look at what this child needs. You have **30 days** from the date you got this letter to appeal.

There are three ways to appeal.

1. **Mail. An appeal form is attached.** You can mail it or a letter about your problem to the
TennCare Solutions Team
P. O. Box 000593
Nashville, TN 37202-0593

2. **Fax.** You can fax your appeal form or a letter to **888-345-5575** (toll free) or **741-1338** (Nashville area).

3. **Call.** You can call the TennCare Solutions Team at **1-800-878-3192** or **253-4479** (Nashville area). Please call during the day if possible, but you can call anytime. If you have an emergency, someone can help you day or night.

If this child needs the care right away, **you may ask for a fast appeal.**

If this child is already getting care, he or she may be able to keep getting it during the appeal. To do this, you must appeal ***within 10 days*** of getting this letter. You must say that you want this child to keep getting the care during the appeal. **If there must be a doctor's order or prescription for the care, this child can keep the care only if there is a doctor's order or prescription.**

We will be happy to talk about this with you. You can call your FSW _____ to find out more.

For special help on appeals for children in DCS custody, you may call the TennCare Consumer Advocates, Phone 1-855-283-0007.

Need special help because you have a health, learning, or other problem? Please let us know. There are several places that can help you. When you call the TennCare Solutions Team at **1800-878-3192** tell them about any help that you need. People with hearing or speech problems can use their **TTY/TDD** machine by calling **1-800-772-7647 or 313-9240 (in the Nashville area.)**

Hay una linea telefonica en Espanol para los consumidores Hispanos de TennCare. Llame al proyecto en Espanol de TennCare al Tel. **1-800-254-7568.**

Important Numbers

TennCare Solutions Team,
P. O. Box 000593
Nashville, TN 37202-0593
PHONE: 1-800-878-3192
FAX: 888-845-5575 (toll-free)

TTY/TDD: 1-800-772-7647
ESPANOL: 1-800-254-7568

Sincerely,
Department of Children's Services

Having problems getting health care or medicine in TennCare?

Need help filing a medical appeal?

Call **1-800-878-3192** for free.

Use this page **only** to file a

TennCare Medical Appeal

Fill out **both** pages. These are **facts we must have to work your appeal.** If you don't tell us all the facts we need, we may not be able to decide your appeal. You may **not** get a fair hearing. Need help understanding what facts we need? Call us for free at **1-800-878-3192.** If you call, we can also take your **appeal by phone.**

1. Who is the person that wants to appeal?

Full name_____Date of birth ____/____/____

Social Security Number_____-_____-_____Or number on their TennCare card _____

Current mailing address_____

City_____State_____Zip Code _____

The name of the person we should call if we have questions about this appeal: ____

A daytime phone number for that person (_____)_____-_____

2. Who filled out this form?

If **not** the person that wants to appeal, tell us your name. _____

Are you a:_____Parent, relative, or friend_____Advocate or attorney_____Doctor or health care provider

3. What is the appeal for? (Place an **X** beside the right answer below.)

____Want to **change health plans.** (Fill out **Part A** on page 2.)

____ **Need care or medicine.** (Fill out **Part B** on page 2.)

____ Have **bills or paid for care or medicine** you think TennCare should pay. (Fill out **Part C** on page 2.)

4. Do you think you have an emergency?

Usually, your appeal is decided within **90 days** after you file it. But, if you have an emergency, you may be able to get an expedited appeal. This means your appeal will be decided in 3 business days. An emergency means that if you don't get a decision on your appeal within 3 business days, it could **seriously jeopardize (put in danger)**:

- your life;
- your physical health;
- your mental health; or
- your ability to reach, get back, or keep your mind and body as healthy as possible.

Do you still think you have an emergency? If so, you can ask TennCare for an expedited appeal. Your health plan will decide if your appeal should be expedited because you have an emergency. If so, then your appeal will be decided in 3 business days from the date TennCare receives your appeal. But, if your health plan decides that your appeal should **not** be expedited, then you will get a hearing within 90 days.

Also, if your doctor thinks you need an expedited appeal, your doctor can go to **tn.gov/tenncare.** Click "Providers," and then click "Miscellaneous Provider Forms" to fill out

a "Provider's Expedited Appeal Certificate". Your doctor should fax the certificate to **1-866-211-7228.** Your health plan will review the certificate and make a decision about your appeal. If your health plan thinks the appeal should be expedited, you will get a decision on your appeal in 3 business days from then. But, if your health plan decides your appeal should **not** be expedited, then you will get a hearing within 90 days from the date you filed your appeal.

5. Tell us why you want to appeal this problem. Include any mistake you think TennCare made. And, send copies of any papers that you think may help us understand your problem.

_____

_____

_____

To see which Part(s) you should fill out below, look at number **3** on page 1.

Part A. Want to change health plans. Name of health plan you want _____

Part B. Need care or medicine. What kind - be specific _____

What's the problem? _____Can't get the care or medicine at all.

__Can't get as much of the care or medicine as I need.

__The care or medicine is being cut or stopped.

__Waiting too long to get the care or medicine.

Did your doctor prescribe the care or medicine? No If yes, doctor's name _____

Have you asked your health plan for this care or medicine? Yes No If yes, when? _____ _____

What did they say?_____

Did you get a letter about this problem? Yes No If yes, the date of the letter_____

Who was the letter from?_____

Are you getting this care or medicine from TennCare now? Yes No

Do you want to see if you can keep getting it during your appeal? Yes No

Does your doctor say you still need it? Yes No If yes, doctor's name _____

If you keep getting care or medicine during your appeal and you lose, you may have to pay TennCare back.

Part C. Bills for care or medicine you think TennCare should pay for

The date you got the care or medicine_____Name of doctor, drug store, or other place that gave you the care or medicine_____Their phone number ( ) _____

Their address_____

Did you **pay for the care or medicine and want to be paid back?** Yes No

If yes, you must send a copy of a **receipt** that proves you paid for the care or medicine.

If you didn't pay, **are you getting a bill?**_____Yes____No

If yes, and you think TennCare should pay, you must send a copy of a **bill.** Tell us the date you first got a bill (if you know). _____

How to file your medical appeal

Then, **mail** these pages and other facts to:

Make a copy of the completed pages to keep.

TennCare Solutions
P.O. Box 593
Nashville, TN 37202-0593

Or, **fax** it (toll-free) to 1-888-345-5575. **Keep a copy** of the page that shows your fax went through. To appeal by **phone**, call 1-800-878-3192 for free.
Have speech or hearing problems? Call our TTY/TDD line for free at 1-866-771-7043.

We do not allow unfair treatment in TennCare.

No one is treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability. If you think you've been treated unfairly, call the Tennessee Health Connection for free at **1-855-259-0701.**