

 WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 7/15/03	Reviewed: 9/17/11 By: PE Last Revision: 10/10/11	Section: PROVIDER NETWORK	Policy No: 048	Pages: 1 of 3 (3 Attachments)
☒ Wraparound ☒ Wraparound-REACH ☒ FISS ☒ Project O-Yeah	Effective Date: 1/1/12	Subject: PARENT ASSISTANCE SERVICES (Service Code 5522 / HCPCS Code 5511)			

I. POLICY

It is the policy of Wraparound Milwaukee/FISS Services/REACH/O-YEAH that individuals in need of Parent Assistance Services receive quality care provided by a trained/authorized Provider. **This service should be structured to meet identified needs/goals within 90 days.**

II. PROCEDURE

A. Definition.

A Parent Assistant is an individual whose role is to:

1. Assist client/parent/caregiver in acquiring parenting skills and/or organizing their household to be a clean and safe environment. The Parent Assistant teaches, models and monitors appropriate child rearing strategies and techniques, and models and teaches household management skills.
2. May provide information on child development, age appropriate behaviors and parental expectations, and childcare activities.
3. Assist the parent/caregiver with securing basic resources such as food, clothing, furniture, medicine, access to support groups, etc.
4. Provides training and assistance with routine household tasks and household management techniques related to the parent/caregiver/client acquiring the skills and competencies necessary to become self-sufficient.

B. Requirements.

1. Agency.

- a. The Agency must have submitted a 15-hour Parent Assistant Training Curriculum that was approved by the Provider Network.
- b. The training Manual that refers to the actual materials used in providing the 15 hours of training must be readily accessible at the Agency for auditor review.
- c. Applicants/Agencies must show evidence of training/certification/education specific to Parent Assistance in the application process.

2. Provider.

- a. Individual Providers of this service must possess a High School Diploma or GED.
- b. **Prior to the provision of service**, a **Statewide Criminal Background Check** must be completed on all Parent Assistants (*see Caregiver Background Check Policy #057*). A copy of the Background Check must be kept in the employee's personnel file. The Agency will be held accountable for ALL requirements/processes referred to in the Background Check policy. A complete Background Check includes the following three components:
 - 1) A completed HFS-64 Background Information Disclosure form (BID form).
 - 2) A Department of Justice (DOJ) Criminal History Record Request.
 - 3) A Department of Health & Family Services (DHFS) letter regarding the status of a person's administrative finding or licensing restrictions.

In addition to meeting the requirement set forth in the Wisconsin Caregiver Law, the Background Check must ALSO meet the requirements set forth in the Milwaukee County Caregiver Resolution.
- c. A Parent Assistant must have a minimum of **15 hours of Agency training prior to service delivery**. For all new Parent Assistant Providers entering the Network, a copy of the

WRAPAROUND MILWAUKEE VERIFICATION OF 15 HOUR TRAINING REQUIREMENT CERTIFICATE (see Attachment 1) and the Provider Agency Parent Assistance Job Description that has been reviewed and signed off on by the Direct Service Provider, must accompany the “Provider ADD Sheet”, which authorizes them to provide services within the system. A copy must be kept in the Agency’s employee file.

- d. **For those Parent Assistants that will be transporting clients, a Department of Motor Vehicle Driving Abstract** must be completed prior to the provision of services (see [Provider Agency Responsibilities/Guidelines Policy #054, II.,B.,9.](#)). A copy of a valid Wisconsin Driver’s License and a copy of the Parent Assistant’s current automobile insurance must be kept in the employee’s personnel file.

3. **Client File.**

- a. **Every Client** should have his/her own file. Files must be maintained as outlined in the [Provider Agency Responsibilities & Guidelines Policy #054](#).
- b. The Agency must receive a **PROVIDER REFERRAL FORM** (Wraparound Milwaukee, REACH, O-YEAH and FISS Services each have their own) from the Care Coordinator/FISS Manager prior to the provision of services. The Referral Form must be filled out in its entirety. A copy or original must be kept in the client’s file.
- c. A **CONSENT FOR SERVICE** form must be completed on every client prior to the provision of services. The consent should be dated and signed by the client (if over age 14) and must be signed by the legal guardian. If the client/enrollee is a legal adult (O-YEAH program), only the client’s signature is necessary. The Consent must specify the Agency providing the service, the service being provided and any other special requirements set forth by the Agency/client. All Consents authorize service for one year from the date of signing. As services should, on average, last 90 days or less, one signed Consent should be sufficient. In very rare occasions, if services go beyond the one-year (12 months) timeframe, another Consent must be signed. The Consent for Service must be kept in the client’s file. **NOTE: The Agency is expected to create their own “Consent for Service” form.**
- d. If a client is going to be transported, a **completed TRANSPORTATION CONSENT FORM** (see Attachment 2) must be in the client’s file prior to the first transport. The Consent must be filled out in its entirety, including the signature/date of the parent/legal guardian. The client should also sign if over age 14, but if he/she does not, this would not preclude the service from being rendered. If the client is a legal adult (O-YEAH program), only the client’s signature is necessary.

4. **Progress Report Log** (see Attachment 3 and the attached Sample – two Log types are included: one for when the client is seen several times during the month and one for when a client might be seen only one time during the month).

- a. Must be completed on every client every month for the duration of service.
- b. The Log must be completed in its entirety. There must be a Note entry for every time the client is seen face-to-face (or when attempted contact is made with the client). Documentation must be accurate and be reflective of the service, as described on the previous page.
- c. The Needs/Goals identified on the Progress Report Log should correlate with what is on the Wraparound Milwaukee / REACH Plan of Care/FISS Referral Form / O-YEAH Future Plan.
- d. The use of “white out” on the Progress Report Log is **NOT permissible**. Errors must be corrected using a straight line to strike out the error, with that error being dated and initialed (Example – ~~Contact~~ C.W. 11/16/04).
- e. The Log must be signed by the parent/legal guardian/caregiver/client for O-YEAH program, Parent Assistant and Wraparound Milwaukee / REACH Care Coordinator/FISS Manager / O-YEAH Transition Specialist. The Log must be signed by the parent/legal guardian/caregiver/client for O-YEAH program before it is sent to the Care Coordinator/ Transition Specialist for Wraparound / O-YEAH authorized services or before it is sent to the Wraparound Fiscal Department for FISS authorized services.

*Note: Pre-signing or altering the Logs in any way is considered fraudulent **behavior** and may be grounds for termination from the **Wraparound Provider Network** and any future contractual/fee-for-service arrangements with Milwaukee County.*

- f. **For Wraparound/REACH/O-YEAH only** - It is the responsibility of the Provider Agency to get the Log to the Care Coordinator **for his/her signature** in a timely manner – **within the first week of the month following the month of services.**
For FISS only – It is the responsibility of the Provider Agency to get the Log to the designated Wraparound Fiscal Department staff in a timely manner – **within the first week of the month following the month of services.** FISS case closure can occur at any time throughout the month. Logs are to be faxed to the designated Wraparound Fiscal Department staff 1 to 3 business days following Provider's final contact with the family.
 - g. It is the responsibility of the Care Coordinator/FISS Manager/Transition Specialist to return the **signed** original/faxed Logs to the Provider Agency in a timely manner – **within 1-3 days after receiving the Log.**
 - h. A copy of the Log must be retained by the Care Coordinator/FISS Manager/Transition Specialist after they sign off. **It is the responsibility of the Care Coordinator/FISS Manager/Transition Specialist to make a copy of the Log before they return it to the Provider.**
For FISS only – The State Bureau of Milwaukee Child Welfare (BMCW) requires FISS Services to have all Logs in their files for audit purposes, as well as to have documentation available for Court, if a child needs to be detained, in order to prove services were offered and to verify the client's level of cooperation.
 - i. **For Wraparound/REACH/O-YEAH Only** - If the Agency is faxing the Log to the Care Coordinator/Transition Specialist for the signature, then a copy of the returned signed faxed Log should be attached to the original Log. When auditors are reviewing Logs, they will be looking for all three signatures (Provider, legal guardian/caregiver/client and Care Coordinator/Transition Specialist).
 - j. The **original** Log (and the attached copy with the Care Coordinator/FISS Manager/Transition Specialist signature on it, if applicable) must be filed in the client's Agency file with the most recent month on top.
5. **Billing.**
- a. **Face-to-face** contact with the client **IS billable.** This includes Child & Family Team meetings, Plan of Care meetings and any other meeting in which the youth/family is being discussed and **is present.** The time spent at such meetings should be billed at the established hourly rate.
 - b. Phone/written contact and "No Shows" must also be documented, but are **NOT billable.**
 - c. Transportation time to and from the client contact is **NOT billable.**
 - d. The Provider Agency must have the completed, signed Log in their possession before they bill for services.
6. **Miscellaneous.**
- a. It is expected that the Parent Assistant be invited to all Team/POC meetings and that he/she attend. If he/she is unable to attend, a verbal update of the status of service provision must be provided to the Care Coordinator/FISS Manager/Transition Specialist.

Any/all of the above requirements may be audited by Wraparound Milwaukee/FISS, the State of Wisconsin, Milwaukee County and/or any program-affiliated auditing body.

Reviewed & Approved by: Bruce Kamradt
Bruce Kamradt, Director

Wraparound Milwaukee

VERIFICATION OF 15 HOUR TRAINING REQUIREMENT

CHECK THE SERVICE(S) TO BE PROVIDED BELOW

Employee Name: _____
(print employee name)

This is a statement of verification that the above named employee has completed in full **ALL TRAINING REQUIRED BY WRAPAROUND MILWAUKEE TO PROVIDE THE FOLLOWING SERVICE(S).**

(Check those that apply)

☐ Mentoring: _____
(List Training Dates Above - Month/Day/ Year)

☐ Parent Assistance: _____
(List Training Dates Above - Month/Day/ Year)

☐ Tutoring: _____
(List Training Dates Above - Month/Day/ Year)

Detailed information related to all training sessions is on file with:

(agency name)

and includes: the date, duration, topic(s) covered; training method (ie: video; written material; workshop, etc) and name of the trainer for each training module or session.

(Wraparound Milwaukee may request this information at any time for quality assurance purposes.)

Agency Director or Designee Signature

Employee Signature

Agency Director/Designee Signature

Employee Signature

Print Name

Print Name

Date Signed

Date Signed

TRANSPORTATION CONSENT FORM

YOUTH/CLIENT NAME: _____ DOB: _____
(Print)

_____ OF _____
(Provider's Name) (Name of Provider Agency)

HAS PERMISSION TO PICK UP AND TRANSPORT _____
(Name of Youth/Client)

FROM _____ THROUGH THE TERMINATION OF SERVICES FROM THIS AGENCY.
(Effective Date)

SPECIAL CONSIDERATIONS/MEDICAL-MEDICATION ISSUES/LIMITATIONS:

Signature of Legal Guardian Relationship to Youth Date

Signature of Youth (should sign if age 14 or over) Date

WITNESSED BY:

Print Name of Witness

Signature of Witness Date Witnessed

Agency Address Agency Phone

EMERGENCY CONTACT:

Name: _____

Address: _____

State: _____ Zip: _____ Phone: _____

Unless otherwise specified, this consent will expire 12 months from the date it was signed. This consent or any part of this consent may be canceled at any time with written notification.

WRAPAROUND MILWAUKEE – Parent Assistance Services Policy – Attachment 3

PROVIDER NETWORK PROGRESS REPORT LOG

Pre-signing or altering of logs is fraudulent behavior and may be grounds for termination from the Network and any future contractual relationships with the County

For: Month Year

Provider's Name/Agency: _____ Phone: _____

Name of Client Being Serviced:_____

(If a sibling /child/parent of an identified enrollee indicate enrollees name): _____

Legal Guardian's Name (not needed for OY): _____ Relationship: _____

Care Coord./Agency, FISS Mngr.or Trans. Spec.:_____Phone:_____

Need/Goal: 1) _____
Strategy: _____

Need/Goal: 2) _____
Strategy: _____

Need/Goal: 3) _____
Strategy: _____

NOTE: ALL NEEDS/GOALS MUST BE ADDRESSED MORE THAN ONE TIME DURING THE MONTH

Overall Monthly Outcomes (circle one # in each row) 1= Poor Progress 3=Satisfactory Progress 5=Excellent Progress

Need/Goal # 1	1	2	3	4	5
Need/Goal # 2	1	2	3	4	5
Need/Goal # 3	1	2	3	4	5

DATE (i.e., 8/29/01)	-TIME FRAME SEEN (i.e.- 4:00 – 7:00 p.m.) -TOTAL TIME SEEN -BILLABLE TIME	<u>ACTIVITY, COMMENTS & PROGRESS RELEVANT TO IDENTIFIED NEEDS/GOALS</u> Type of Contact: FF = Face to Face PH =Phone W =Written NS = No Show MTG = Child and Family Team/POC mtg./other youth-family meeting Must have one note entry for every contact made REMINDER: Phone/written contacts/No Shows are <u>NOT</u> billable for Parent Asst. and Tutoring but must be documented.
	Time Frame: Total Time: Total Billable Time: 	Location of FF/NS/MTG: _____ Type of Contact: (circle one) FF PH W NS MTG Activity/conversation engaged in, client's mood/any significant behaviors/reactions:

**Legal Guardian/Caregiver's
Signature or Client Signature for OY
Date**

Provider's Signature

Date _____

Wraparound/REACH Care Coord.
FISS Manager or Trans. Spec. Signature
Date

Agency Administration Approval: _____ **Date:** _____

Using billing code (check one): Tutoring - ☐ 5521 or ☐ H2021 Parent Assistant - ☐ 5522 or ☐ 55111

<u>Check One</u>	<u>Check One</u>
☐ Wraparound	☐ Tutoring
☐ REACH	(5521/H2021)
☐ FISS	☐ Parent Asst.
☐ O-YEAH	(5522/55111)

PROVIDER NETWORK
PROGRESS REPORT LOG

For: Month _____ Year _____

Pre-signing or altering of logs is fraudulent and may be grounds for termination from the Network and any future contractual relationships with the County

Provider’s Name/Agency: _____ Phone: _____

Name of Client Being Serviced: _____
(If a sibling /child/parent of an identified enrollee indicate enrollees name): _____

Legal Guardian’s Name (not needed for OY): _____ Relationship: _____

Care Coord./Agency, FISS Mngr. or Trans. Spec.: _____ Phone: _____

Need/Goal: 1) _____
Strategy: _____

Need/Goal: 2) _____
Strategy: _____

Need/Goal: 3) _____
Strategy: _____

NOTE: ALL NEEDS/GOALS MUST BE ADDRESSED MORE THAN ONE TIME DURING THE MONTH

Overall Monthly Outcomes (circle one # in each row) 1= Poor Progress 3=Satisfactory Progress 5=Excellent Progress					
Need/Goal # 1	1	2	3	4	5
Need/Goal # 2	1	2	3	4	5
Need/Goal # 3	1	2	3	4	5

DATE (i.e., 8/29/01)	-TIME FRAME SEEN (i.e.- 4:00 – 7:00 p.m.) -TOTAL TIME SEEN -BILLABLE TIME	ACTIVITY, COMMENTS & PROGRESS RELEVANT TO IDENTIFIED NEEDS/GOALS <u>Type of Contact:</u> FF = Face to Face PH =Phone W =Written NS = No Show MTG = Child and Family Team/POC mtg./other youth-family meeting Must have one note entry for every contact made <u>REMINDER:</u> Phone/written contacts/No Shows are NOT billable for Parent Asst. and Tutoring but must be documented.
	Time Frame: Total Time: Billable Time: 	Location of FF/NS/MTG: _____ Type of Contact: (circle one) FF PH W NS MTG Activity/conversation engaged in, client’s mood/any significant behaviors/reactions:

DATE (i.e., 8/29/01)	-TIME FRAME SEEN (i.e.- 4:00 – 7:00 p.m.) -TOTAL TIME SEEN -BILLABLE TIME	<u>ACTIVITY, COMMENTS & PROGRESS RELEVANT TO IDENTIFIED NEEDS/GOALS</u> <u>Type of Contact:</u> FF = Face to Face PH =Phone W =Written NS = No Show MTG = Child and Family Team/POC mtg./other youth-family meeting Must have one note entry for every contact made <u>REMINDER:</u> Phone/written contacts/No Shows are <u>NOT</u> billable for Parent Asst. and Tutoring but must be documented.
	Time Frame: Total Time: Billable Time: 	Location of FF/NS/MTG: _____ Type of Contact: (circle one) FF PH W NS MTG. Activity/conversation engaged in, client's mood/any significant behaviors/reactions:
	Time Frame: Total Time: Billable Time: 	Location of FF/NS/MTG: _____ Type of Contact: (circle one) FF PH W NS MTG. Activity/conversation engaged in, client's mood/any significant behaviors/reactions:
	Time Frame: Total Time: Billable Time: 	Location of FF/NS/MTG: _____ Type of Contact: (circle one) FF PH W NS MTG. Activity/conversation engaged in, client's mood/any significant behaviors/reactions:
TOTAL TIME:	TOTAL BILLABLE TIME:	

_____ Legal Guardian/Caregiver's Signature or Client Signature for OY Date _____	_____ Provider's Signature Date _____	_____ Wraparound/REACH Care Coord., FISS Manager or Trans. Spec. Signature Date _____
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Agency Administration Approval: _____ **Date:** _____
Using billing code (check one): Tutoring - ☐ 5521 or ☐ H2021 Parent Assistant - ☐ 5522 or ☐ 55111
c/wrapcmn/erdman/IPNProgressReportForm4 8/11/08 11/23/10

Check One Check One
☒ Wraparound ☐ Tutoring
☐ REACH (5521/H2021)
☐ FISS ☒ Parent Asst.
☐ O-YEAH (5522/55111)

PROVIDER NETWORK PROGRESS REPORT LOG

Pre-signing or altering of logs is fraudulent and may be grounds for termination from the Network and any future contractual relationships with the County

For: Month July Year 2010

Provider's Name/Agency: Jackie Miller - Caring, Inc. Phone: (414) 222-3322

Name of Client Being Served: Paula Brown (Parent)
 (If a sibling /child/parent of an identified enrollee indicate enrollee's name): Jason Brown

Legal Guardian's Name (not needed for OY): N/A Relationship: N/A

Care Coord./Agency, FISS Mngr. or Trans. Spec.: Julie Miles - Milw. Services Phone: (414) 252-8909

Need/Goal: 1) Improve parenting skills
 Strategy: Teach "hands-off" behavioral techniques 1x per week.

Need/Goal: 2) Improve knowledge of community resources for clothing & household items.
 Strategy: Provide info on area resources & take parent to clothing & furniture stores as needed.

Need/Goal: 3) _____
 Strategy: _____

NOTE: ALL NEEDS/GOALS MUST BE ADDRESSED MORE THAN ONE TIME DURING THE MONTH

Overall Monthly Outcomes (circle one # in each row)	1= Poor Progress	3=Satisfactory Progress	5=Excellent Progress
Need/Goal # 1	1	2	3
Need/Goal # 2	1	2	3
Need/Goal # 3	1	2	3

DATE (i.e., 8/29/01)	-TIME FRAME SEEN (i.e.- 4:00 – 7:00 p.m.) -TOTAL TIME SEEN -BILLABLE TIME	ACTIVITY, COMMENTS & PROGRESS RELEVANT TO IDENTIFIED NEEDS/GOALS
7/5/10	Time Frame: 10:00 AM - 12:00 Noon Total Time: 2 hours Billable Time: 2 hrs.	Type of Contact: FF = Face to Face PH = Phone W = Written NS = No Show MTG = Child and Family Team/POC mtg./other youth-family meeting Must have one note entry for every contact made REMINDER: Phone/written contacts/No Shows are NOT billable for Parent Asst. and Tutoring but must be documented. Location of FF/NS/MTG: <u>Client home</u> Type of Contact: (circle one) <u>FF</u> PH W NS MTG Activity/conversation engaged in, client's mood/any significant behaviors/reactions: <u>Spoke with Mrs. Brown about "hands-off" parenting techniques. Provided info on the use of time-outs need for consistency & follow-through. She mentioned that she thought it would be difficult to implement this type of technique as her children would not listen. Provided reassurance that with consistency & follow through that it can work. Will practice giving a time-out.</u>

OVER →

DATE (i.e., 8/29/01)	-TIME FRAME SEEN (i.e.- 4:00 - 7:00 p.m.) -TOTAL TIME SEEN -BILLABLE TIME	ACTIVITY, COMMENTS & PROGRESS RELEVANT TO IDENTIFIED NEEDS/GOALS Type of Contact: FF = Face to Face PH =Phone W =Written NS = No Show MTG = Child and Family Team/POC mtg./other youth-family meeting Must have one note entry for every contact made REMINDER: Phone/written contacts/No Shows are <u>NOT</u> billable for Parent Asst. and Tutoring but must be documented.
7/8/10	Time Frame: 9:30 AM - 12:00 Noon Total Time: 2.5 hours Billable Time: 2.5 hrs.	Location of FF/NS/MTG: <u>Client's home / community</u> Type of Contact: (circle one) <u>(FF)</u> PH W NS MTG. Activity/conversation engaged in, client's mood/any significant behaviors/reactions: Took Ms. Brown to 3 area second hand clothing stores in her neighborhood. Assisted with choosing the best items for the cost. Provided her with 2 furniture store addresses that we will be visiting in ^{DI/8 PE} search of a dresser for Jason. Ms. Brown was very thankful for the assistance. Helped put items away upon return to client's home.
7/12/10	Time Frame: 9:00 AM - 10:30 AM Total Time: 1.5 hours Billable Time: 1.5 hrs.	Location of FF/NS/MTG: <u>Client's home</u> Type of Contact: (circle one) <u>(FF)</u> PH W NS MTG. Activity/conversation engaged in, client's mood/any significant behaviors/reactions: Continued to work on educating Ms. Brown about "hands-off" parenting techniques. Practiced implementing time-outs. She seemed more hopeful that she would be able to implement the technique!
7/14/10	Time Frame: 9:30 AM - 9:45 AM Total Time: 15 minutes Billable Time: 0	Location of FF/NS/MTG: <u>Client's home</u> Type of Contact: (circle one) FF PH W <u>(NS)</u> MTG. Activity/conversation engaged in, client's mood/any significant behaviors/reactions: Arrived at the home to pick up Ms. Brown to go to the furniture stores. No answer! Called into home. No Answer. Left a message on voice mail to please call this writer regarding missed appointment & to reschedule.

TOTAL TIME: 6 hrs. 15 min.

TOTAL BILLABLE TIME: 6 hours

Paula Brown
Legal Guardian/Caregiver's
Signature or Client Signature for OY
Date 7/29/10

Jacelin Miller
Provider's Signature
Date 7/30/10

Julie Miles
Wraparound/REACH Care Coord.,
FISS Manager or Trans. Spec. Signature
Date 8/11/10

Agency Administration Approval:

P.K.

Date: 8/2/10

Using billing code (check one): Tutoring - ☐ 5521 or ☐ H2021 Parent Assistant - ☐ 5522 or ☐ 55111
c/wrapcmn/erdman/IPNProgressReportForm4 8/11/08 11/23/10