Family Intensive Treatment (FIT) Model

Requirement: Specific Appropriations within the General Appropriations Act

Purpose: To ensure the implementation and administration of this proviso project, the Managing Entity shall require that Behavioral Health Providers providing FIT services (herein referred to as "FIT Team Providers") adhere to the service delivery and reporting requirements described herein.

I. LEVEL OF CARE DESCRIPTION

Florida's Family Intensive Treatment (FIT) Teams model is a promising, evidence-informed practice to deliver community-based behavioral health treatment and support to families involved in the child welfare system and affected by parental substance use disorder. FIT Teams employ a multidisciplinary approach to behavioral health intervention within the broader system of care, providing early identification and coordination, as well as support to families through navigation of the child welfare and treatment processes. Florida's FIT model is evidence-informed and research-supported, with evaluations demonstrating positive outcomes for participating families[1].

II. ELIGIBILITY

FIT Teams serve families that meet the following criteria:

1. Eligible for publicly funded substance abuse and mental health services pursuant to s. 394.674, F.S.; including individuals who meet all other eligibility criteria but are underinsured;
2. At least one parent/guardian meets the criteria for a substance use disorder; and
3. At the time of referral to FIT:
    - A child in the family has been determined to be "unsafe," with a priority given to families with children 0 – 10 years old;
    - For children in out-of-home care, the family must have a child welfare case management plan with the permanency goal of reunification, or a concurrent case plan that includes reunification as a permanency goal; and
    - The eligible parent/guardian is either willing to participate in treatment or has been court-ordered to engage in services. In either circumstance, the FIT Team is expected to actively engage and retain the parent/guardian in treatment, as this is a critical component of FIT services.

While eligibility is determined by at least one parent/guardian in the home meeting the criteria, all household members may receive and benefit from services and enhanced coordination. This approach supports family-focused treatment and ensures that all members address issues that may impact the family's success from both behavioral health and child safety perspective. Each parent/guardian who meets the eligibility criteria is included in performance measures.

[1] SAMH Program Information – Publications, Florida Intensive Treatment (FIT) Evaluation Report https://www.myflfamilies.com/services/samh/publications (accessed April 2026)

FIT Teams may also serve families whose net income is at or above 150% of the federal poverty level, applying a sliding fee scale in accordance with Section 394.76, Florida Statutes, and Chapter 65E-14.018, Florida Administrative Code, when no other options at this level is available.

Referrals

FIT Teams shall accept referrals for eligible families, subject to available capacity, from Child Protective Investigators, Lead Agencies, Child Welfare Case Management Organizations, Managing Entities, and other providers of services. Other stakeholders working with families with child welfare involvement, such as engagement programs and the Dependency Court system, may also refer to FIT Teams.

III. SERVICE DESCRIPTION

FIT Teams are implemented by community behavioral health providers who work collaboratively with families to explore their culture, beliefs, and values and collaborate to identify strengths and assess family needs. Through that process, individualized treatment goals are developed and adjusted as needed. Families and FIT Teams also work together to identify, non-clinical supports, which may include coaching parents to address ineffective coping strategies and teaching or modeling positive approaches to managing their children - particularly in the context of everyday stressors such as work, legal involvement, financial pressures, and healthcare needs.

Program Goals

The goals of the FIT Team model are to:

1. Provide early identification of at-risk families and immediate access to intensive substance use and co-occurring mental health treatment services for families with child welfare involvement with early engagement strategies, such as at case initiation or case transfer, when a child in the family has been determined to be “unsafe”.
2. Implement a multidisciplinary approach, including Clinicians, Case Managers, and Recovery Peer Support Specialists.
3. Plan and deliver service in coordination with Lead Agencies, Child Welfare Professionals, Managing Entities, and other providers.
4. Integrate evidence-based treatment for substance use disorders, parenting interventions, and therapeutic treatment for all family members into one comprehensive treatment approach. This comprehensive approach includes coordinating clinical children’s services which are provided outside of the FIT team funding.
5. Identify family-driven pathways to recovery and promote sustained recovery through inclusive, responsive treatment and involvement in recovery-oriented services and supports.
6. Promote increased engagement and retention in treatment.
7. Facilitate concurrent planning between child welfare case planning and treatment plan goals, to integrate the family’s strengths and needs with their Dependency case plan.
8. Advocate for families and assist in navigating the child welfare process.

9. Promote treatment completion and continued care through linkage to ongoing support services and natural supports.
10. In collaboration with Lead Agencies and Child Welfare Case Management Organizations, the goals are to:
    - Promote the safety of children in the child welfare system whose parents/guardians have a substance use disorder;
    - Develop a safe, nurturing and stable living situation for these children as rapidly and responsibly as possible;
    - Provide information to inform the safety plan, ongoing Family Functioning Assessments (FFA), and any other relevant status updates;
    - Reduce the number of out-of-home placements when safe to do so; and
    - Reduce rates of re-entry into the child welfare system.

Staffing Requirements

FIT Team staffing configurations combine practitioners with diverse backgrounds in education, training, and experience. This range of skills and expertise enhances the team's ability to provide comprehensive, needs-based care. FIT Teams must minimally include the following positions:

Program Manager

The Program Manager position must be a full-time employee with full clinical, administrative, and supervisory responsibility for the team. The Program Manager must meet one of the following qualifications:

- Hold a Florida license in one of the following professions:
  - Licensed Clinical Social Worker, Marriage and Family Therapist, or Mental Health Counselor licensed in accordance with Chapter 491, Florida Statutes
  - Psychologist licensed in accordance with Chapter 490, Florida Statutes

OR

- Be a master's level clinician operating under the supervision of a licensed clinical supervisor in accordance with Chapter 491 or Chapter 490, Florida Statutes. The supervising clinician must dedicate a minimum of 0.15 FTE to the FIT team, hold an active Florida license as a Qualified Supervisor, and provide ongoing clinical oversight. The master's level Program Manager must possess a minimum of three years of experience working with adults with substance use disorders..

Behavioral Health Clinician

The Behavioral Health Clinician position must be a master's level clinician who holds a degree from an accredited university or college with a major in psychology, social work, counseling, or other behavioral science. The Behavioral Health Clinician provides evidence-based therapeutic services and integrates

behavioral health goals with caregiver protective capacities and parenting interventions. These services may include:

- Conducting comprehensive substance use assessments that evaluate the relationship between substance use and mental health conditions;
- Assessing and monitoring participants' stage of change readiness and stage of treatment;
- Utilizing engagement strategies and motivational interviewing techniques to enhance participation and commitment to treatment;
- Conducting integrated treatment utilizing cognitive behavioral approaches and relapse prevention strategies; and
- Providing interventions that are aligned with each participant's stage of change readiness.

The Behavioral Health Clinician also provides consultation and training to other team members on integrated assessment and treatment practice related to co-occurring disorders, including crisis intervention and individual and group sessions. Preference is given to candidates with a minimum of two years of experience working with adults with substance use disorders. Caseload are determined by the Program Manager but **shall not exceed 15 clients**.

FIT Case Manager

The FIT Case Manager position requires, at minimum, a bachelor's degree in a behavioral science field. The FIT Case Manager provides rehabilitation and support services under clinical supervision and is an integral member of the treatment team. Rehabilitation and support services include:

- Planning;
- Ongoing assessment;
- Psychoeducation;
- Skills development;
- Monitoring;
- Problem solving; and
- Advocating.

The FIT Case Manager may assist with coordinating referrals initiated by the FIT Team and with follow-up of other needed services; however, this position does not function as the child welfare case manager.

Preference is given to candidates with a minimum of one year of experience working with adults who have behavioral health needs and child welfare involvement. Candidates who hold a bachelor's or master's degree in another field must have at least three years of experience working with adults with substance use disorders. Caseloads are determined by the Program Manager but **shall not exceed 20 clients**.

Recovery Peer Specialist

The Recovery Peer Specialist position requires certification through the Florida Certification Board or, alternatively, an individual with lived experience in recovery from substance use disorders for a minimum of two years, along with at least one year of work experience as a Recovery Peer Specialist.

Peer Specialists facilitate wellness management and recovery-oriented strategies. They model recovery-based skills for participants and provide coaching and consultation to promote self-direction and sustained recovery in both individual and group settings. Peer Specialists participate in all team activities (e.g., treatment planning and documentation) and offer essential expertise to the team, fostering a culture in which each member's perspectives, preferences, and lived experiences are recognized, respected, and integrated into care. Advocacy and support services include::

- Planning;
- Mentoring;
- Psychoeducation;
- Recovery Support;
- Skill building;
- Sharing resources;
- Building community and relationships; and
- Facilitating recovery groups.

Individuals hired without Florida Certification Board certification are allowed one year from the date of hire to obtain certification. Caseloads are determined by the Program Manager and **shall not exceed 20 clients**.

Programmatic Requirements

FIT Teams must be trained in the use of evidence-based substance use treatment and parenting practices found effective for serving families with child welfare involvement.

FIT Teams must include the following activities, tasks, and provisions:

1. Access to crisis support 24 hours a day, 7 days a week for participants in case of emergency.
2. Recovery peer support services to promote recovery, engagement and retention in treatment, and skill development
3. Case management services to address the basic support needs of the family and coordinate the therapeutic aspects of services provided to all family members regardless of payer source
4. Coordination of services and support with child welfare professionals
5. Individualized treatment provided at the level of care that is recommended by ASAM or LOCUS placement criteria
6. Document FIT activities and family progress in the Child and Family Wellbeing data system, currently the Families Safe Families Network (FSFN), which will eventually transition to the Florida

Comprehensive Child Welfare Information System (FL CCWIS). At a minimum, the following FIT activities shall be documented:

- Monthly Progress Notes – A summary of the services and supports provided, progress during the reporting period, and any ongoing recommendations for care.
- Interim Progress Note (if applicable) – An updated Monthly Progress Note provided at any critical juncture during the family's child welfare investigation or case management process, upon request of a child welfare professional.
- Discharge Summary – A summary of the services and supports received during the episode of care

7. Intensive in-home treatment, inclusive of individual and family counseling, related therapeutic interventions, and treatment to address substance use disorders, based on individual and family needs and preferences
8. Group treatment to address substance use disorders, based on individual and family needs and preferences
9. Trauma-informed treatment services for substance use disorders and co-occurring substance use and mental health disorders
10. Therapeutic services and psychoeducation in:
    - Parenting interventions for child-parenting relationships and parenting skills
    - Natural support development, including the family when appropriate
    - Relapse prevention skill development and engagement in the recovery community
11. Care coordination as reflected in the FIT Team's treatment plan, including a Multi-Disciplinary Team (MDT) to promote access to a variety of services and supports as indicated by the needs and preferences of the family, including but not limited to:
    - Domestic violence services
    - Medical and dental health care
    - Basic needs such as supportive housing, housing, food, and transportation
    - Educational and training services
    - Supported employment, employment and vocational services
    - Early child care and education services
    - Legal services
    - Other services identified in the FIT Team's case management plan

Services and Supports

The FIT Team is inclusive of the following covered services and activities as defined in Chapter 65E-14.021, Florida Administrative Code[2]:

- Aftercare – Individual and Group
- Assessment
- Care Coordination

[2] Florida Department of State - Florida Administrative Code & Florida Administrative Register www.flrules.org/ (accessed April 2026)

- Case Management
- Crisis Support/Emergency
- Incidentals Expenses
- Information and Referrals
- In-Home and On-site
- Intensive Case Management
- Intervention – Individual and Group
- Medication-Assisted Treatment
- Outpatient – Individual, Family, and Group
- Outreach
- Recovery Support – Individual and Group
- Supported Employment
- Supportive Housing/Living

The FIT Team shall include the following, as detailed below:

Active Engagement

Because FIT services are voluntary, FIT Teams should utilize engagement strategies, such as motivational interviewing to foster ongoing participation and strengthen relationships with participants. The FIT Team should also monitor for indicators that a participant may require more assertive engagement. Such indicators may include missing appointments; limited rapport or lack of trust in the therapeutic relationship; high-risk behaviors; or substance use that interferes with the participant's ability to engage in treatment.

Assessments

The FIT Team must assess parental capacity, functioning, substance use and co-occurring mental health conditions, family history, and trauma. All assessment tools should be completed, as appropriate, within the first 30 days off enrollment.

The assessment process must include review of prior evaluations and assessments by child welfare professionals, as well as any available behavioral health treatment history. Results from all assessments are incorporated into the biopsychosocial assessment and used to inform treatment planning and interventions.

- *American Society of Addiction Medicine (ASAM) or Level of Care Utilization System (LOCUS) Criteria*
  Complete the ASAM or LOCUS Criteria to address the parent(s)/guardian(s)' needs, obstacles and liabilities, as well as the caregiver's strengths, assets, resources and support structure to determine level of care **upon admission**.

- *Daily Living Activities (DLA-20): Alcohol-Drug Functional Assessment*
  The DLA-20 must be completed within the first 30 days of admission to establish a functional baseline. After the baseline is established, it should be readministered at regular intervals to monitor changes in functional capacity over time. At a minimum, the DLA-20 must be readministered **every ninety (90) days**; however, it may be completed more frequently based on provider preference. In addition, the DLA-20 must be administered at key transition points, including:
  - at discharge, except in cases of unplanned discharge;
  - when there is a change in level of care; and
  - following a significant life event.

  If a client's mental health, cognitive functioning, or level of independence demonstrates a noticeable improvement or decline, the DLA-20 may be readministered to document the change. Administration of the DLA-20 without direct contact with the client is considered invalid. Direct contact includes in-person, telehealth/video, or telephone interaction. In cases of unplanned discharge, the score from the most recent DLA-20 administration should be used as the discharge score.

- *Caregiver Protective Capacities*
  Review the caregiver protective capacity rating(s) completed by the Child Protective Investigator or Child Welfare Case Manager from the most recent Family Functioning Assessment (FFA). The FIT Team will complete an **internal baseline** rating of the caregiver's protective capacities based on information gathered during the assessment process and integrate these capacities into the treatment plan goals. Caregiver protective capacities will be evaluated **monthly** through progress updates, during treatment plan reviews, and at discharge. These internal ratings are not intended to replace the assessments conducted by child welfare professionals but rather to align language and support a more comprehensive discussion of the caregiver's progress.

- *Biopsychosocial Assessment*
  The Biopsychosocial Assessment shall describe the biological, psychological, and social factors that may have contributed to the recipient's need for services. The evaluation synthesizes the results of all administered assessments and includes a brief mental status exam, diagnostic/clinical impression and preliminary service recommendations based on the findings and interview of the client and family. Refer to Chapter 65D-30, F.A.C. for further requirements of the Biopsychosocial Assessment.

Treatment Planning Process

As a core competency of the Integrated Practice Model, behavioral health providers must support and address child welfare outcomes by enhancing caregiver protective capacities. By identifying diminished caregiver protective capacities alongside behavioral health needs, the FIT team can develop targeted interventions to address family needs. This approach aligns with the Child Welfare Practice Model which requires child welfare professionals to identify reunification criteria, objectively evaluate caregiver protective capacities, and assess behavioral changes in the parent/guardian that enhance these capacities.

The FIT Team participates in or coordinates MDT staffings following enrollment and at least every 30 days thereafter, requesting participation from child welfare professional(s), parent(s)/guardian(s), and other relevant parties, including caregiver(s), foster parent(s), mentor(s), teacher(s), primary health care provider(s), and other service provider(s).The MDT is responsible for the development and ongoing evaluation of the treatment plan and/or case plan, including any alterations that may prove necessary.

Transition and Discharge

Successful transition planning begins at admission, is family-centered, and continues throughout the family's treatment. Families are apprised of the appropriate community resources, linked to those services and actively participate in all phases of the transition planning process. Referral to community providers must occur in a timely and systematic manner prior to discharge. The process concludes with the coordination and implementation of services and the family's transition to the least restrictive level of care.

- **Transfers to Another FIT Team**

  Managing Entities must assist with coordinating transfers when a family plans to move out of the area and wishes to continue FIT services. The originating Managing Entity will contact the receiving Managing Entity to confirm capacity and propose transfer date. Once confirmed, the originating FIT team must, with family consent, send the receiving team a comprehensive referral packet.

  FIT teams are required to accept transfers if they have available capacity. Upon receipt, the receiving team shall review the participant's clinical records, conduct an initial assessment, and develop a new treatment plan.

- **Discharge Process**

  No more than thirty (30) calendar days prior to discharge, an MDT staffing shall be conducted to address the family's planned discharge from the FIT program. This discharge MDT staffing shall include the FIT Team and request participation from child welfare professional(s), the parent(s), and other relevant parties, including caregiver(s), foster parent(s), mentor(s), teacher(s), primary health care provider(s), and other service provider(s).

  The discharge MDT staffing must address the family's behavioral health and any ongoing relapse prevention and recovery services needs, including supports such as: Alcoholics Anonymous (AA), Narcotics Anonymous (NA), any faith-based group or other recovery resources; the physical health care needs of both parents and children; support services such as housing assistance, supported employment, and financial benefits; and community services such as childcare, early intervention programs, therapies, and community-based parenting programs.

  A discharge summary must be completed that outlines the family's needs and confirms all referrals to community-based services. The summary must be provided to the family upon discharge, and a copy must be submitted to the child welfare professional within seven (7) calendar days.

  In the event of an unplanned discharge, the FIT team must convene an MDT staffing as soon as disengagement is identified to discuss strategies for re-engagement or to plan for next steps following discharge. These actions must be documented in the discharge summary and provided to the child welfare professional within seven (7) calendar days.

- **Discharge Reasons**

  The following are appropriate discharge reasons within the FIT model:

  COMPLETED TREATMENT: Participant made significant progress toward rehabilitation goals and engagement in community-based care is optimal.

  GOAL CHANGE: Participant is discharged due to a change in the child welfare case goal. This discharge reason is used when the permanency goal has been modified, and the participant chooses to discontinue treatment. In such cases, this discharge type may be used in lieu of 'Disengaged'. If the participant does not opt for discharge, the FIT Team may continue providing services until treatment is complete.

  TRANSFER TO A HIGHER LEVEL OF CARE: Participant requires transfer to a higher level of care (such as inpatient care). This reflects that maximum benefit has been achieved at the current level of care and yet a higher level of care is needed. If the participant refuses to transfer and disengages, the discharge will be defined as disengaged.

  TRANSFER TO ANOTHER FIT PROVIDER: Participant is discharged due to transferring to another FIT Team Provider where they continue services.

  MOVED: Participant moved out of the service area. This discharge definition is used if the participant is not transferring to another level of care or to another FIT team provider.

  JAIL/PRISON: Participant is discharged due to incarceration.

  DISENGAGED: Participant requests discharge or chooses not to participate, despite best efforts by the FIT team.

  DIED: Participant is discharged due to death.

IV. OUTCOME MEASURES

An ongoing quality improvement process will be implemented by each FIT provider to ensure fidelity to the core components of FIT. The quality assurance process ensures alignment with the FIT Guidance Document, the FIT Manual, the provider's evidence-based practice, requirements for licensing, funding and credentialing, and other identified practices utilized within the FIT model.

The core components of FIT all require diligent efforts on behalf of the FIT teams. These practices are captured quantitatively by performance measures, but an ongoing quality assurance process validates the caliber of services provided using documentation and client feedback. The state of practice implementation and understanding of core components can be assessed through the use of staff interviews, training completion, peer reviews. While the FIT provider has internal processes of quality assurance, the MEs and DCF are also integral monitors of FIT services. The quality assurance process includes the following:

1. Fidelity to evidence-based models being practiced
2. Ongoing trainings and completion of Recommended Education and Training
3. Documentation in required systems, such as FSFN and clinical files or electronic health records
4. Adherence with the communication protocol to engage and re-engaging clients

5. Timeliness of service delivery
6. Clinical monitoring of intensity of treatment and length of stay
   a. Internal file reviews
   b. Peer file reviews
   c. MEs continually monitor length of stay for clinical appropriateness
   d. MEs review client documentation for clinical justification for treatment exceeding 12 months
7. Engagement and involvement of families and stakeholders in treatment
8. Feedback from FIT families
9. Teaming with child welfare and other providers in the community

The ME will request monthly by the 8th day of each month following service delivery a Client Information Form, from each FIT Team provider for each client that provider has enrolled in treatment for over a year. This form satisfies the quality assurance requirements outlined in the FIT Manual; while acknowledging the length of stay is not standardized but depends on clinical treatment goals, client progress, input from the entire multi-disciplinary team, and other various factors that may arise during treatment.

Programmatic Performance Measures and Methodologies

The Managing Entity shall include the following performance measures and methodologies in each FIT Team Provider subcontract:

1. Upon successful treatment completion, *95 percent of eligible parents/guardians served* will be living in a stable housing environment:

- Stable housing is defined as: Independent Living (Alone, with Relatives, with Non-Relatives) or Dependent Living (with Relatives, with Non-Relatives), Foster Care/Home (including Extended Foster Care for ages 18-21) or Supported Housing.
- The numerator is the total number of eligible parents/guardians discharged as Completed Treatment during the reporting period who are living in a stable housing environment.
- The denominator is the total number of eligible parents/guardians discharged as Completed Treatment during the reporting period.
- Individual provider performance between 90 percent and 94 percent will be considered below target but not be subject to financial consequences.

2. Upon successful treatment completion, *95 percent of eligible parents/guardians served* will have stable employment:

- Stable employment is defined as: Active military, overseas; Active military, USA; Full Time; Unpaid Family Worker (A family member who works at least 15 hours or more a week without pay in a family-operated enterprise); Part Time; Retired; Homemaker (Manages household for family members); Student; or Disabled. *Note: If an individual refuses to work because that are making money through illegal activities, the client must be coded as Unemployed.*
- The numerator is the total number of eligible parents/guardians discharged as Completed Treatment during the reporting period who have stable employment.
- The denominator is the total number of eligible parents/guardians discharged as Completed Treatment during the reporting period.

3. Upon successful treatment completion, *90 percent of eligible parents/guardians served* will improve their level of functioning, as measured by the Daily Living Activities (DLA-20): Alcohol-Drug Functional Assessment.
    - Measure of improvement is based on change in the average DLA-20 score, calculated from the initial score to the final recorded score.
    - The numerator is the total number of eligible parents/guardians discharged as Completed Treatment during the reporting period with an overall functioning score that is higher than the initial recorded score.
    - The denominator is the total number of eligible parents/guardians discharged as Completed Treatment during the reporting period who have more than one DLA-20 score.
4. Upon successful treatment completion, *90 percent of eligible parents/guardians served* will improve their Caregiver Protective Capacities as rated by the FIT Team.
    - Measure of improvement is based on changes in the Caregiver Protective Capacities ratings.
    - The numerator is the total number of eligible parents/guardians discharged as Completed Treatment during the reporting period with Caregiver Protective Capacities that are higher than the initial recorded rating.
    - The denominator is the total number of eligible parents/guardians discharged as Completed Treatment during the reporting period who have more than one Caregiver Protective Capacities rating.

Beginning Fiscal Year 2026-2027, the Network Service Providers shall collect, and the Department and Managing Entities analyze baseline data for the following potential measures using currently collected data via the FIT Access Database. During the baseline data collection period, these measures will be used only for monitoring and evaluation. They will not be used to evaluate provider performance or to impose corrective action, financial penalties, or other adverse contractual consequences. The Department and the Managing Entities will evaluate the effectiveness and reasonableness of adopting these additional measures for future implementation. The measures will be adopted effective July 1, 2028, unless objections are raised.

5. On an annual basis, *80 percent of all discharge summaries* must be completed and provided to the child welfare professional[3] within seven (7) calendar days of discharge date.
    - Measure evaluates the timeliness of communication with child welfare professionals. Prompt sharing of this information is critical to the child welfare professionals' decision-making.
    - The numerator is the number of discharge summaries completed and provided to the child welfare professional within seven (7) calendar days of the discharge date.
    - The denominator is the total number of discharges during the reporting period with a value in both the "Discharge Date" and "Date Discharge Summary Sent to Child Welfare" fields.

[3] Measure applies only to families with child welfare involvement at the time of discharge

6. On an annual basis, *55 percent of all discharged parents/guardians* are expected to demonstrate maintained or improved level of functioning, as measured by the Daily Living Activities (DLA-20): Alcohol-Drug Functional Assessment.

    - Measure of maintained or improved level of function is determined by the average DLA-20 score from initial assessment to the discharge, or last recorded score.
    - The numerator is the number of eligible parents/guardians discharged during the reporting period whose final overall functioning score is equal to or greater than their initial score.
    - The denominator is the number of eligible parents/guardians discharged during the reporting period who have more than one DLA-20 score.

7. On an annual basis, *50 percent of all discharged parents/guardians* are expected to demonstrate improved parenting capacity, as measured by the Caregiver Protective Capacities rated internally by the FIT Team.

    - Measure of improvement is determined by a change in the Caregiver Protective Capacities rating from the initial rating to the discharge, or last, recorded rating.
    - The numerator is the total number of eligible parents/guardians discharged during the reporting period whose Caregiver Protective Capacities rating was higher than the initial recorded rating.
    - The denominator is the total number of eligible parents/guardians discharged during the reporting period who have more than one Caregiver Protective Capacities rating.

8. Upon successful completion, *at least 55 percent of eligible parents/guardians* will demonstrate a 20% or greater improvement in their average (i.e., mean) DLA-20 assessment score from admission to discharge.

    - Percentage of change is determined by subtracting the admission score from the discharge score, dividing by the admission score, and multiplying by 100.
    - The numerator is the number of eligible parents/guardians who successfully complete treatment and demonstrate a 20% or greater improvement in their average DLA-20 assessment score from admission to discharge.
    - The denominator is total number of eligible parents/guardians who successfully complete treatment during the reporting period and have both an admission and discharge DLA-20 assessment score.

V. REPORTING REQUIREMENTS

The Department and Managing Entity may request ad hoc data from the Network Service Providers as needed.

- **Access Database for FIT Teams**

  The Department shall provide each Managing Entity with a Microsoft Access database for each FIT Team. The Managing Entity shall require, through its subcontracts, that each FIT Team enter all client data into the Access database and export the data monthly. The Network Service Provider

shall submit FIT data to the Department no later than the 8th day of the month in which services were delivered.

Monthly and annual service targets shall be established by the Managing Entity, taking into account the FIT Team's capacity, the needs of the families served, and geographical considerations. Targets should reflect the expectation that families will remain engaged in treatment and aftercare services for several months.

If a FIT Team fails to meet the minimum performance measures, the Managing Entity may impose a corrective action plan or appropriate financial consequences in accordance with applicable contractual provisions.

The provider will follow performance measures as outlined by LSFHS's As Negotiated Targets document.

- **Appendix A – FIT Return on Investment Quarterly Report**

  This quarterly report is designed to measure and quantify the return on investment of services in both financial and human terms. This report must be submitted on a quarterly basis.

- **Budget**
  - FIT Team Providers must submit an annual budget within 30 days before contract execution and annually - 30 days before the fiscal year, or upon request.
  - The provider is required to enter actual services provided (encounter data), using the covered services available in the LSF Health Systems Contract System, into the LSF Health Systems Data System as required by the contract.

VI. INCIDENTAL EXPENSES

Incidental expenses pursuant to chapter 65E-14.021, Florida Administrative Code, are allowable under this program Network Service Providers must comply with all applicable state purchasing guidelines, adhere to any established review and approval process, and consult the Managing Entity regarding allowable purchases.

Prior to utilizing incidental funds, FIT Teams must explore all other available resources with the family, including eligibility for food, cash, and medical assistance through the Department of Children and Families' Automated Community Connection to Economic Self Sufficiency (ACCESS) program. Additional information regarding the ACCESS program is available at http://www.myflorida.com/accessflorida/[4].

The FIT Team Provider must utilize a minimum of 3% of the annual award amount on Incidental Expense services, as defined in Rule 65E-14.021(4)(k)4.b.(V), F.A.C., to the extent the primary need for such services demonstrably removes barriers and supports the family's recovery or reunification goals as documented in the family's treatment plan. All Incidental Expense services must be documented in the family's treatment plan.

VII. THIRD-PARTY SERVICES

Services provided by the core FIT Team staff and funded through FIT contract dollars may not be billed to any third-party payers.

At a minimum, each FIT Team must be licensed to provide outpatient substance abuse services in accordance with Chapter 65D-30, Florida Administrative Code. If additional service components, for which

[4] Accessed April 2026

the FIT Team Provider is not licensed and required to meet, individualized treatment needs, including but not limited to, detoxification; residential treatment; crisis stabilization; medication management; aftercare, or other specialized services, the FIT Team must refer to the individual to the appropriate level of care or qualified service provider.

The FIT Team shall coordinate and collaborate with all involved providers, as well as the individual and the family, to ensure services are integrated into the overall treatment plan and to monitor progress toward established treatment goals.

For services provided outside of the core FIT Team staff, the FIT Team Provider shall seek reimbursement from all available third party payers for services rendered to individuals, including: commercial insurers, TRICARE, Medicare, Health Maintenance Organizations (HMOs), Managed Care Organizations (MCOs), or any other payer that is contractually or legally obligated, to participate in the cost of providing services for a specific individual.

The FIT Team Providers shall also seek reimbursement for any Medicaid-reimbursable service from Medicaid (or the applicable MCO) when the individual is a Medicaid enrollee. Additionally, the FIT Team Provider shall assist families who may be eligible for Medicaid in completing the Medicaid application process and obtaining required eligibility documentation, pursuant to Chapter 65E-14,014(2), Florida Administrative Code. The FIT Team remains responsible for ensuring immediate access to services for admitted individuals, regardless of payer source.

The Family Intensive Treatment (FIT) Model Guidelines and Requirements will be administered according to DCF Guidance 18, which can be found at following link using the applicable fiscal year: https://www.myflfamilies.com/services/samh/providers/managing-entities

APPENDIX A - FIT RETURN ON INVESTMENT QUARTERLY REPORT

The Return on Investment (ROI) Quarterly Report analyzes the fiscal impact of the FIT model and demonstrates how the state's investment in the program generates measurable benefits. The report compares program expenditures with quantifiable cost savings and reduced utilization of other state-funded services. In addition to financial metrics, it captures human outcomes, including improvements in participant health, functioning, and other social indicators resulting from program participation.

Managing Entities must complete this report on a quarterly basis and request access to the ROI Quarterly Report in Smartsheet, please designate a single point of contact responsible for data submission and provide the individual's name and email address.

Managing Entities must submit points of contact to: HQW.SAMH.ManagingEntitiesInquiries@myflfamilies.com

Reports are due on October 20, January 20, April 20, and August 15.

APPENDIX B – FIT TEAM MODEL PROCESS

Research of the Florida FIT Team model includes rigorous evaluation reports and a peer-reviewed published article that together support its classification as a promising, evidence-informed practice.

Evaluation efforts used quasi-experimental designs, including propensity score matching, to compare outcomes for families served by FIT with similar families not receiving the intervention. These evaluations have documented positive effects on key child welfare outcomes, such as reduced likelihood of additional allegations of maltreatment, improved family stability, and increased rates of achieving permanency.

In addition, a peer-reviewed article published in an academic journal presents findings from a longitudinal analysis of FIT implementation, reinforcing the positive associations between the model and improved family outcomes[5].

The FIT Team Model Process

At time of referral, the FIT Team must:

- Review the referral to ensure it meets FIT eligibility criteria:
    - This can include staffing with the referral source.
    - If the referral does not meet criteria, the FIT Team Provider will staff the case with the referral source and recommendations and linkage to appropriate services are made and documented.
- Access the initial and/or ongoing FFA from the FSFN system[6], if completed.
- Review the FFAs for the diminished caregiver protective capacities.
- Contact child welfare professional to acknowledge receipt of the referral and receive any additional information.
- Review case plan, when available.
- Review FSFN for any prior investigations.
- If FIT Team is full, a waitlist is maintained. All referred families are contacted, given information about status on waitlist and provided referrals for interim services to meet any immediate needs. Weekly phone contact is maintained for all clients on FIT waitlist.

Upon accepting a referral, the FIT Team will:

- Assign the referral to FIT Team (Behavioral Health Clinician, FIT Case Manager and Recovery Peer Specialist).
- Contact the family as soon as possible (within two business days) to explain the FIT Team approach, answer questions, and set up enrollment meeting
- Ensure that initial and recurring efforts to contact and engage the referred family are documented.
- Determine which FIT Team member(s) will participate in the enrollment meeting.

[5] Yampolskaya, S., Sowell, C., Walker-Egea, C., Hanak-Coulter, J., & Pecora, P. J. (2024). *Family Intensive Treatment for child welfare involved caregivers with substance misuse issues: Safety, permanency and well-being outcomes*. **Clinical Social Work Journal, 52**(2), 104–116. https://doi.org/10.1007/s10615-023-00917-8

[6] Eventually transitioning to the Florida Comprehensive Child Welfare Information System (FL CCWIS)

Upon enrollment, the FIT Team will:

- Meet with family and complete all consents required by provider agency.
- Ensure that a release of information is completed for the child welfare professional and any other formal and informal providers and supports involved with the family.
- Contact the child welfare professional to provide disposition of referral, schedule an MDT staffing, and arrange to be present at all teaming activities, such as case planning conference, mediation, staffings, urgent/emergent staffing, or court hearings, etc.

Within the first 30 days after enrollment, the FIT Team will:

- Complete required FIT initial assessments.
- Complete a biopsychosocial based on all child welfare information, results of FIT assessments, and interview with the parent/guardian and family.
- Based on clinical assessments and identified diminished caregiver protective capacities, a treatment plan is developed with the family, FIT team, the child welfare professional, and other providers involved with the family.
- Begin substance use treatment to include relapse prevention planning utilizing an evidence-based model.
- Coordinate specialized services; for example: joint home visits, in-home interventions, parenting programs, child services, peer services, incidental funding, etc.
- Evaluate family's need for early child care and housing or to apply for eligibility for food, cash and medical assistance or use of incidental funds.
- Complete all required FSFN documentation, at a minimum a monthly progress notes and update at any critical juncture.

During ongoing treatment, the FIT Team will:

- Complete additional assessments as appropriate or required.
- Participate in or coordinate frequent MDT staffings (at least monthly), requesting participation from child welfare professional(s), parent/guardian(s), and any other relevant parties such as caregiver(s), foster parent(s), mentor(s), teacher(s), primary health provider(s), and other provider(s).
- Review treatment plans, child welfare professionals' FFA-Ongoing, progress updates, and scaling of caregiver protective capacities. Any section scaled as a "C" or "D" is included as an area of focus in the treatment plan.
- Continue to evaluate family's need for early child care and housing or to apply for eligibility for food, cash and medical assistance or use of incidental funds.
- Participate in teaming activities, such as case planning conference, mediation, MDT staffings, urgent/emergent staffing, or court hearings, etc.
- Complete all required FSFN documentation, at a minimum a monthly progress notes and update at any critical juncture.

During Continued Care, the FIT Team Provider will offer ongoing continued care services once clinical services are determined to be completed. This can be done through individual services and/or attendance at an aftercare group and is typically provided by the FIT Case Manager or Recovery Peer Specialist.

During Transition and Discharge, the FIT Team will:

- Complete updated assessments, such as the DLA-20: Alcohol-Drug and rating of the caregiver protective capacities.
- Provide progress updates to inform the child welfare case manager's ongoing assessments of caregiver protective capacities.
- Consult with the child welfare professional(s) to determine the appropriate time for child welfare case closure. This includes agreement that the caregivers have enhanced their caregiver protective capacities to the point where there are no longer danger threats within the home and the children are safe.
    - Families may be transitioned if there is a goal change to Termination of Parental Rights (TPR), however the family does not have to be discharged at this time if actively engaged and expresses a desire for continued FIT services.
    - Families may be transitioned at any time the family declines ongoing treatment with the FIT Team.
    - Participate in or coordinate an MDT staffing no more than thirty (30) calendar days prior to discharge to discuss case transition with the FIT Team, requesting participation from child welfare professional(s), parent(s)/guardian(s), and other relevant parties, including caregiver(s), foster parent(s), mentor(s), teacher(s), primary health care provider(s), and other service provider(s), except in cases of unplanned discharge when the parent(s) are unavailable.
- Coordinate linkage with community resources to ensure any ongoing care/aftercare 14 calendar days prior to discharge, except in the case of unplanned discharge.
- Assist with coordination of follow-up services.
    - Complete discharge summary and provide to the child welfare professional within seven days of discharge.
    - Complete all required FSFN documentation.

APPENDIX C – RESOURCES & TRAINING

Department of Children and Families Learning and Resource Network

My FL Learn Training Portal

https://www.myflfamilies.com/my-fl-learn[4]

The My FL Learn training portal is available to all FIT Teams and Managing Entities. This portal offers a vast selection of free trainings from written content, prerecorded broadcasts or live training opportunities.

FIT teams can access My FL Learn by creating an account as an external user. Topics in the My FL Learn training portal include:

Florida Safe Families Network (FSFN) – Florida's Statewide Child Welfare Information System

Child Protective Investigative Process

Child Welfare System Care

Collaboration, Partnership and Multidisciplinary Teams

Child Welfare and Substance Use Disorders

Co-Occurring Mental and Substance Use Disorders

Child Development and Safety Planning

Human Trafficking and Sexual Abuse

Dependency Courtroom Training

FSFN Trainings (Three-Part Prerecorded FSFN Training)

FIT Teams can also access My FL Learn to complete a prerecorded FSFN training series.

Part 1:

FSFN & Policy: Navigating FSFN for CPIs and Case Management

1. Introduction to FSFN
2. Navigation & Commence Investigations Desktop
3. Case Notes

Part 2:
FSFN & Policy: Navigating FSFN for CPIs and Case Management

1. Investigative Assessments
2. File Cabinet
3. Closing Investigations

Part 3:

FSFN: System for CPIs and Case Management 2022 – Simulation

Office of the State Courts' Legal Resource Guide

Dependency Court Benchbook

https://www.flcourts.gov/Resources-Services/Office-of-Family-Courts/Family-Court-in-Florida/Dependency/Dependency-Benchbook[4]

The Dependency Court Benchbook is a compilation of promising practices as well as a legal resource guide. This comprehensive tool provides information regarding legal and non-legal considerations in dependency cases.

FIT teams and other stakeholders can access the Dependency Court Benchbook. Topics in the Dependency Court Benchbook include:

Dependency Case Management Flowchart

Family-Centered Practice in Dependency Court

Trauma and Child Development

Service and Treatment Considerations in Dependency Court

Child Safety Considerations

National Center on Substance Abuse and Child Welfare (NCSACW)

Tutorials for Substance Use Disorder Treatment Professionals

https://ncsacw.acf.gov/training/tutorials/[4]

This course is divided into five modules. Each module builds on the previous one. After passing the knowledge assessment at the end of the course, you will be able to print a certificate of completion. This certificate can be submitted to NAADAC, the Association for Addiction Professionals, for 4.5 Continuing Education Units (CEUs).

Module One: Primer on CW and Dependency Court Systems for Substance Use Disorder Treatment Professionals.

Module Two: Engaging Child Welfare-Involved Families in Treatment

Module Three: Effective Treatment for Child Welfare-Involved Families

Module Four: Special Considerations for Children Whose Parents Have Substance Use Disorders

Module Five: Collaborative Strategies to Effectively Serve Child Welfare Families Affected by Substance Use Disorders

The Florida Alcohol and Drug Abuse Association (FADAA)

Child Welfare & Family Court Opioid Use Disorder Trainings

https://www.training.fadaa.org/[4]

These comprehensive modules focus on increasing understanding of the opioid crises in Florida, the effects on family systems, and how to engage recovery resources. The trainings were funded by the federal State Targeted Response to the Opioid Crisis (O-STR) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Training Topics include:

Opioid Training Module

Child Welfare System Case Studies Applying Motivational Interviewing

Other Training Modules for Judicial System Representatives

Other Training Modules for Child Welfare Representatives

FIT Integrating Behavioral Health and Child Welfare Practice Manual

The FIT Manual was developed by stakeholders involved in the Caregiver Protective Capacity (CPC) and the Clinical Practice Workgroups as a guide for providers with the purpose of transcending vision to practice. Through years of review and experience, the FIT Manual has evolved to serve as a guideline for best practices and assist in further implementation. Continued implementation of the FIT model must be strategic and build upon improvements to the systems of care in place. As integrated systems of care continue to be developed, it is important to recognize that it is an evolving process, encouraged by improvements in communication, coordination, collaboration, and integration. Achieving these gains will require that we look closely at the systems in place and be prepared to modify the infrastructure to reinforce these changes as we go. This will take very strategic work and significant effort to eventually achieve integration of an effective practice and supporting infrastructure.

The FIT Manual provides an outline for this integrated approach to treatment, including an overview of Florida's Child Welfare Practice Model, the core components of the FIT Model, steps for implementing the FIT model, and a guide for integrated treatment planning. A copy of the FIT Manual is located on the Department's SAMH Program Information – Publications page: https://www.myflfamilies.com/services/samh/publications[4]

Contingency Management (CM)

Contingency management (CM) is an evidence-based intervention that involves reinforcing abstinence and recovery related behaviors. CM is widely considered the most effective treatment for stimulant use disorder; however, CM also has evidence as an effective treatment for alcohol, cannabis, and tobacco use disorders. CM has been successfully implemented nationwide by the U.S. Department of Veterans Affairs (VA).

Expanding access to high-quality CM services for the treatment of SUDs represents an important opportunity to accelerate efforts to address the overdose crisis, as well as the other substantial public health harms and costs related to untreated SUDs.

The U.S. Department of Health and Human Services Workgroup on Implementation Strategies for Contingency Management has prepared a Report to Congress which discusses opportunities and considerations for entities overseeing CM implementation. https://aspe.hhs.gov/reports/contingency-management-treatment-suds[4]

Florida Division of Early Learning & Assistance with Early Child Care and Voluntary Prekindergarten (VPK)

The most important time in a child's development is the first five (5) years. Maltreatment to young children introduces trauma during critical periods of brain development, which can have long lasting effects. High-quality early child care and education programs are strategies to mitigate the risk of maltreatment and promote the well-being of young children. Assisting families with access to early child

care and education services supports families by providing respite care for caregivers, while also supporting employment and higher education opportunities.[7]

The Florida Division of Early Learning, in partnership with the state's 30 early learning coalitions, helps families access early child care and education options. The Child Care Resource and Referral program can help:

- Find quality early learning programs.
- Connect with local community resources.
- Engage in learning and development.

School Readiness (SR) programs offer financial assistance to income-eligible families to access high-quality child care. The Voluntary Prekindergarten (VPK) program is a free educational program that prepares 4-year-olds for academic success.[8]

To apply for SR child care, enroll a child in VPK, or get information about other early education resources, refer a family to the local early learning coalition (ELC). The list of contact information for the local ELCs is https://www.fldoe.org/schools/early-learning/directory[4].

[7] https://www.casey.org/economic-supports-research/ (accessed April 2026)
[8] https://www.fldoe.org/schools/early-learning/parents/ (accessed April 2026)