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Build 18.9 Job Aid

Health Services

**Functionality for Caseworkers, Case Planners,
Case Managers and CPS Worker/Monitors**



**CONNECTIONS Training Project
Professional Development Program
Rockefeller College
University at Albany**

Version 2.1

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This Job Aid is available on the CONNECTIONS intranet site:
OCFS intranet home page > CONNECTIONS > Step-by-Step/Job Aids/Tips

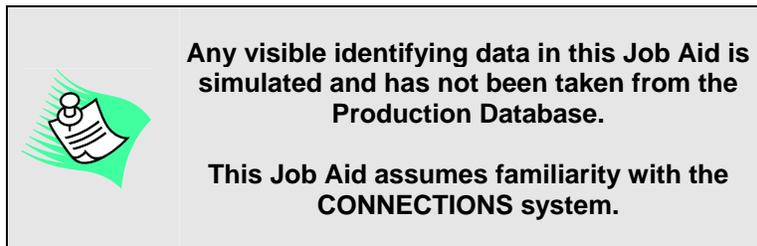
The OCFS CONNECTIONS intranet site also contains information about trainings offered to support you in your work with CONNECTIONS.

Introduction

This Job Aid provides a detailed overview of the CONNECTIONS system changes being introduced with Build 18.9 and Build 18.9.1- specifically information about health services. The job aid is intended for all CONNECTIONS users who will be responsible for recording health information in CONNECTIONS. These are both workers assigned a role and specialists.

The following detailed information is contained in this Job Aid:

- the security and confidentiality of health information;
- health services in CONNECTIONS;
- accessing the *Health Services* window;
- viewing, recording and modifying health information; and
- generating forms and reports.



Health Services

Local districts and authorized agencies are responsible for providing comprehensive medical services for all children in foster care, for documenting such services, and for maintaining current records. Federal and New York State statutes and regulations define the services that must be provided as well as standards for the confidentiality of medical information. The Health Services functionality was developed to support the continuity and integrity of the child's medical care and completion of activities required by federal or state mandate.

Build 18.9 will introduce new windows supporting the recording of a variety of health-related information; this includes the following:

- medications
- hospitalizations
- diagnoses & treatment recommendations
- health narratives
- allergies
- clinical appointments
- Early Intervention services

The addition of the health service component does not replace the child's individual medical history maintained by the district or agency since CONNECTIONS does not support an on-line medical record. Beyond required components, there is some latitude in determining how extensively health services information in CONNECTIONS will be used. Agencies may list all medical information gathered and services provided, but this is not required. If an agency already had computerized health records prior to Build 18.9, they may choose to limit data entry to mandated components. When health information is recorded timely and accurately, any responsible agency or district staff with appropriate role/security will immediately have access to the previously recorded information. This will benefit case planning, and improve the chances that a child with health care needs will receive necessary care, and that continuity of care will not be broken.

New York State requires the recording of health information for foster children and for PINS remands in New York City placed in voluntary foster care agencies. Recording this information is recommended for children under court-ordered supervision remaining at home or in an out of home non-foster care setting, and for all indicated, open CPS cases since there is responsibility and accountability for the child's health and well-being. Recording health information for children receiving preventive or protective services in their own home is optional.

In the case of Early Intervention, local districts are required to inform parents who are subjects of an indicated report of child abuse or maltreatment about the Early Intervention Program, and local districts are also required to refer any children in the family under the age of three to the program. It is recommended that EI referrals be made for all foster children under the age of three. These referrals, and any subsequent Early Intervention evaluation and services, will be recorded in Health Services in CONNECTIONS.



Refer to Local Commissioners Memorandum (LCM) 04-OCFS-LCM-04 for more information on Early Intervention standards and procedures when referring a child that is the subject of an indicated report of child abuse or maltreatment.



All medical and mental health information about a child in foster care must be kept confidential in accordance with Social Services Law (section 372). Such information may be shared only with health practitioners, health staff, caseworkers, direct care workers, and foster and adoptive parents (with some exceptions) when they need it to provide adequate care and supervision. Refer to the Health Services Security topic for more details on health information confidentiality and security.

The Health Services window includes the following tabs:

- Child Health Info
- Clinical Appointment
- Early Intervention
- Bio Family Health Info
- HIV Risk Assessment
- Health Narrative

Information that must be recorded on the **Child Health Info** tab includes:

- Current Allergies and the start date (may be estimated)
- Current Medications and the start date (may be estimated)
- Current Durable Medical Equipment and the start date (may be estimated)
- Overnight Hospitalizations
- Primary Care/Medical Home contact
- After Hours Agency Health contact, when applicable.

Information that must be recorded on the **Clinical Appointment** tab includes specific information related to:

- Initial Assessments in 5 domains (physical/medical, dental, developmental, mental health, and substance abuse for children 10 years of age and older) for children entering foster care
- Periodic well-child care exams (physical/medical)
- Periodic preventive care exams (dental)
- “Immunizations up to date” indicator for initial and well-child physical/medical appointments
- Discharge exam
- The initial diagnosis of a chronic illness. If the chronic condition existed prior to foster care, record using the “Diagnosis at Intake” appointment type.
- All emergency and crisis intervention appointments

Information that must be recorded on the **Early Intervention** tab includes:

- Referral date for all children under three in an indicated child protective case
- Any subsequent evaluation, result and program the child attends, as applicable

Information that must be recorded on the **Bio Family Health Info** tab includes:

- Health Information - Genetic or hereditary conditions to the extent known for the biological parents, siblings or other relatives of children in foster care
- Biological Mother- medications, alcohol, and drug use during pregnancy for children in foster care
- Any other information that impacts the current or future health of the child in foster care

Information that must be recorded on the **HIV Risk Assessment** tab includes the date on which the child's HIV risk assessment was completed.

Information that must be recorded on the **Health Narrative** tab includes critical health-related information about the child that requires the higher level of security that Health Services provides (as opposed to Progress Notes).

All agencies should be entering health information concerning the current status of children in foster care and NYC children on PINS remand status. It is not necessary to enter all the information from medical files into CONNECTIONS, but you will need to record information on the child's current status and any required information acquired.

For children currently in care or children coming into care, enter required health information contemporaneous with receipt of documentation of the service.

The Security of Health Services Information

All medical and mental health information about a child in foster care must be kept confidential in accordance with Social Services Law (section 372). Such information may be shared only with health practitioners, health staff, caseworkers, direct care workers, and foster and adoptive parents (with some exceptions) when they need it to provide adequate care and supervision. Access to CONNECTIONS health information will align with confidentiality guidelines by providing added security. It is role-specific and includes a new level of security whereby a particular agency can be designated as responsible for recording health information on a child-specific basis. Two new Business Functions (VIEW HEALTH and MAINT HEALTH) have also been added in order to support the unique health security requirements.



When performing a person merge, health information is not automatically merged. Health information should be reviewed and manually updated.

General Confidentiality Guidelines

Staff should have access to individual identifiable information only if their specific job responsibilities cannot be accomplished without access. Steps that agencies can take to protect confidential health information include the following:

- Maintain a separate health record in a place with limited access (e.g. locked filing cabinet).
- Do not discuss health information about a child on your caseload with colleagues unless they have a “need to know.”
- Do not leave health records on your desk when you’re not using them.
- Communicate carefully with the recipient when mailing/faxing health information so that person will be looking for the documents.
- Make sure caregivers of children with HIV infection are familiar with the re-disclosure statement and the laws about re-disclosure.
- If you are logged on to CONNECTIONS, always lock your computer if you are going to be away from the desk, even for a few minutes (80% of security breaches are unauthorized people using an authorized user’s computer, not hacking in from the outside).
- Avoid transmitting confidential information over unencrypted Internet or unsecured public connections. The best practice is to use Outlook using an HSEN connection.
- During the course of your work, you may have to leave phone messages or an email message in your attempts to contact someone concerning health information. Please be careful not to include confidential messages in voicemail or email. Instead of using email to send a co-worker confidential information, use a Reminder To-Do in CONNECTIONS.

Health information to be safeguarded includes:

- prior and current illnesses or health concerns;
- immunization history;
- current medications (prescription and over-the-counter);
- allergies (food, medication and environmental);
- reports of medical examinations, diagnostic tests and treatments, including reports on whether an applicant or recipient has had an HIV-related test or has been diagnosed as having AIDS, HIV infection or an HIV-related illness; and
- hereditary conditions or diseases in the biological family history, including details of pregnancy, labor and delivery.

CONNECTIONS Health Security

For those assigned the role of Caseworker—or for those staff who are accessing the Health module using the Business Function VIEW HEALTH or MAINT HEALTH who are not in the local district with case management responsibility—there is an added level of security needed to view and maintain health information. Their agency must be designated as responsible for entering the health information for a particular child. Designation of health responsibility is done by a Case Manager or Case Planner who determines that an agency will be responsible for entering health information for a specific child. The designation of health responsibility works in conjunction with the Business Functions for those staff that do not have a role in the case. The Early Intervention tab is the exception to the system security rules. Any worker with a role in the stage can view or maintain information on the Early Intervention tab for any child under four years of age.



When performing a person merge health information is not automatically merged. Health information should be reviewed and manually updated.

Access to Health by Role for Open Stages, Through the Workload:

- CASE MANAGER - or those in his/her unit hierarchy may view and modify all children in the stage.
- CASE PLANNER - or those in his/her unit hierarchy may view and modify all children in the stage.
- CPS WORKER/ MONITOR - or those in his/her Unit Hierarchy may view and modify all children in the stage.
- CASE WORKER - or those in his/her unit hierarchy may view and modify all children on their caseload for whom their agency has been designated responsible.
- STATE WORKER - or those accessing his/her workload may view and modify all children in the stage.



Accessing an Assigned Workload based on Agency Access (Build 17 Security) will not grant you access to Health Information.

Implied Role Access to Health Information

- INVESTIGATORS - The Primary and Secondary Investigators in a CPS INV stage open concurrently with an FSS stage may view all children.

Access to Health by Business Function for Open Stages, Through Case Search

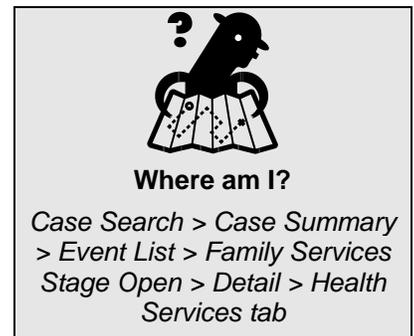
Agency staff, including health specialists, who are responsible for *recording* health information but have no role in the stage must be assigned the MAINT HEALTH *and* CASE/PER SRCH Business Functions by the Security Coordinator, in accordance with OCFS Guidelines, to access the Health Services tab. They will access the health component using Case Search and cannot access any other tabs in the Family Services Stage (FSS) unless other Business Functions provide such access. Once assigned the above Business Functions, the worker's ability to view health information for specific children is as follows:

- CASE MANAGER AGENCY - Workers in the same agency as the Case Manager may modify health information for all children.
- OUTSIDE CASE MANAGER'S AGENCY - Workers outside the Case Manager's agency may modify health information for all children for whom their agency has been designated responsible.



Agency staff responsible for *viewing* health information with no role in the stage must be assigned the VIEW HEALTH *and* CASE/PER SRCH Business Functions by the Security Coordinator, in the accordance with OCFS Guidelines, to access the Health Services tab. Once assigned the above Business Functions, the worker's ability to view health information for specific children is as follows:

- CASE MANAGER AGENCY - Workers in the same agency as the Case Manager may view health information for all children.
- OUTSIDE CASE MANAGER'S AGENCY - Workers outside the Case Manager's agency may view health information for all children for whom their agency has been designated responsible.



Access to Health by Business Function for Closed Stages, Through Case Search:

A worker's ability to access health information in a closed stage is dependent upon the worker's agency (i.e., Case Manager, Case Planner, Caseworker's agency) and any designation during the open stage.

Agency staff assigned the MAINT HEALTH and CASE/PER SRCH Business Functions by the Security Coordinator, in accordance with OCFS Guidelines, to access the Health Services tab will have the following access:

- CASE MANAGER AGENCY - Workers can maintain health information for all children.
- CASE PLANNER AGENCY - Workers in the district or agency of the Case Planner who was assigned at the time of stage closure can maintain health information for all children. This also includes Case Planners that were end-dated subsequent to the closing of the stage.
- CASE WORKER AGENCY - Workers in the district or agency of the Case Worker who was assigned at the time of stage closure may maintain health information for any child for whom the agency had been designated responsible.

Agency staff assigned the VIEW HEALTH and CASE/PER SRCH Business Functions by the Security Coordinator, in accordance with OCFS Guidelines, to access the Health Services tab will have the following access:

- CASE MANAGER AGENCY - Workers with access to the closed stage may view health information for all children.
- CASE PLANNER AGENCY - Workers in the district or agency of the Case Planner who was assigned at the time of stage closure may view health information for all children.
- CASE WORKER AGENCY - Workers in the district or agency of the Case Worker who was assigned at the time of stage closure may view health for the child(ren) for whom their agency was designated responsible.



Where am I?

*Case Search > Case Summary
> Options > Stage Maint >
Maintain Health*



If the Case Planner was unassigned prior to stage closure and the agency was never designated as responsible, the staff cannot access health information for the closed stage.

If the agency was designated as responsible, the worker will be able to view and/ or maintain health information for children that they were designated responsible for up to the point that their designation ended.



Where am I?

*Case Search > Case Summary
> Event List > Family Services
Stage Open > Detail > Health
Services tab*

Designating Health Responsibility

Since health information is confidential and protected by various federal and state laws, access to it is restricted in CONNECTIONS. The Designate Health Responsibility functionality allows for recording a specific agency to be designated for maintaining health information, allowing caseworkers with a role in the stage and health specialists with the MAINT HEALTH business function to record Health Services information for children who are placed in their agency.

For open stages, the *Designate Health Responsibility* window can be accessed in modify mode by the Case Manager and Case Planner and in view-only mode for all other workers. The window may be accessed in a view-only mode by all workers for closed stages.

This window is accessed from any tab on the *Health Services* window by clicking on the **Options** menu and selecting the **Designate Health Responsibility** command, which is available from all tabs.



Step-by-Step: Accessing the Designate Health Responsibility Window

- 1 Click on the **WORK** button on the CONNECTIONS Toolbar.
The Assigned Workload displays.
- 2 Select the appropriate FSS stage and click on the **Tasks...** button.
The Family Services Stage window displays.
- 3 Click on the **Health Services tab**.
The Health Services window displays.
- 4 Select a child from the Child List grid.
*The **Options** menu displays.*
- 5 Click on the **Options** menu and select the **Designate Health Responsibility** command.
The Designate Health Responsibility window displays.

Designate Health Responsibility - Hill, Jean - S:23846537/C:21974770

File Options Help

Case Name: Hill, Jean Case Initiation Date: 12/5/2006

Manage Health Responsibility

Tracked Child

	Name	Sex	Person ID	Age	DOB
▶	Hill, Megan	F	28924524	2	10/7/2004
	Hill, Kelly	F	28924523	16	12/7/1990
	Hill, William	M	28924474	8	12/23/1997

Responsible Agency List

Agency Name
▶ Albany County Dss

Add

Health Responsibility History

	Child Name	Child ID	Child DOB	Responsible Agency Name	Responsibility Start Date	Responsibility End Date
	Hill, Megan	28924524	10/7/2004	Albany County Dss	12/12/2006	
▶	Hill, Kelly	28924523	12/7/1990	Albany County Dss	12/12/2006	
	Hill, William	28924474	12/23/1997	Albany County Dss	12/12/2006	

End Responsibility

Save Cancel Close

The *Designate Health Responsibility* window is comprised of grids and various buttons. The Tracked Child grid is populated with all tracked children from the **Stage Composition** tab. You may select multiple children from the Tracked Child grid but only one agency may be selected at a time for designating responsibility in order to save the responsibility. When an agency is currently responsible for a child, the child's row will display shaded in the Tracked Child grid. The Tracked Child grid is comprised of the following columns:

- Name** The child's name (Last, First, Middle Initial).
- Sex** The child's gender.
- Person ID** The child's unique, CONNECTIONS system-generated identification number.
- Age** The child's age (computed using the child's date of birth and current system date).
- DOB** The child's date of birth.

The Responsible Agency List is populated with any agency name that has a worker with a role in the stage. This list allows for designating a specific agency for maintaining health information, allowing caseworkers with a role in the stage and health specialists with the MAINT HEALTH business function to record Health Services information for children who are placed in their agency.

The Health Responsibility History grid, located in the lower half of the window, records all saved health responsibilities. This grid contains the following columns:

Child Name	The child's name (Last, First, Middle Initial).
Child ID	The child's unique, CONNECTIONS system-generated identification number.
Child DOB	The child's date of birth.
Responsible Agency Name	The name of the agency designated to maintain health information.
Responsibility Start Date	The date on which the agency was designated as responsible for the child.
Responsibility End Date	The date on which the agency was no longer designated as responsible for the child..

The *Designate Health Responsibility* window contains the following buttons:

Add	<p>The Add button enables once a child(ren) and an agency is selected. Clicking on the Add button designates health responsibility.</p> <p>If another agency is currently designated to maintain health for the child, the previous health responsibility is end-dated with the system date after responding Yes to the following message:</p> <p><i>“Current Responsibility will be ended and new responsibility will be recorded. Do you wish to continue?”</i></p> <ul style="list-style-type: none">• Clicking on the Yes button adds the record to the Health Responsibility History grid.• Clicking on the No button closes the message and de-selects all previous choices.
End Responsibility	<p>This button enables when a record is selected from the Health Responsibility History grid. Clicking on the End Responsibility button end-dates an agency's current health responsibility. The following message displays:</p> <p><i>“Current Responsibility will be ended. Do you wish to continue?”</i></p> <ul style="list-style-type: none">• Clicking on the Yes button populates the Responsibility End Date field with the system date.• Clicking on the No button closes the message and de-selects the history record.
Save	<p>The Save button enables when a responsibility has been added to the grid or when a history record has been end-dated. Clicking on this button saves work that has been recorded or modifications that have been made.</p>

Cancel

The **Cancel** button is disabled until a modification is made on the open window. Clicking on this button cancels any changes made to the information on the tab since the last save. The following message displays upon clicking on the **Cancel** button:

*“Do you want to cancel?
Unsaved data and/or narrative(s) will be lost.”*

- Clicking on the **Yes** button discards the unsaved changes.
- Clicking on the **No** button ends the cancellation request and returns to the window with the current changes that were made.

Close

Clicking on this button closes the window and displays the *Health Services* window. If any unsaved changes exist on the window when you click on this button, the following message displays:

*“Do you want to Exit?
Unsaved data and/or narrative(s) will be lost.”*

- Clicking on the **Yes** button discards the unsaved changes and closes the window.
- Clicking on the **No** button closes the message without closing the window; all changes remain pending.



Step-by-Step: Designating Health Responsibility

- 1 On the *Designate Health Responsibility* window, select the appropriate child from the Tracked Child grid by clicking on the box to the left of the child's name. To select more than one child hold down the **Ctrl** key and select the box to the left of each child's name.
- 2 Select the desired agency by clicking on the box to the left of the agency name.
*The **Add** button enables.*
- 3 Click on the **Add** button.
*The **Save** button enables and the new responsibility will be added to the Health Responsibility History grid below.*
- 4 Click on the **Save** button.
- 5 Click on the **Close** button.
The Health Services window displays.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Options menu > Designate
Health Responsibility command*



If the agency does not appear on the list, the Case Manager or Planner must assign a caseworker from that agency using the **Assign** button located on the *Assigned Workload*.



Step-by-Step: Updating an Existing Designated Health Responsibility

- 1 On the *Designate Health Responsibility* window, select the appropriate child from the Tracked Child grid by clicking on the box to the left of the child's name.
- 2 Select the desired agency by clicking on the box to the left of the agency name.
*The **Add** button enables.*
- 3 Click on the **Add** button.
The following message displays:
“Current Responsibility will be ended and new responsibility will be recorded. Do you wish to continue?”
- 4 Click on the **Yes** button to designate the newly selected agency as responsible.
*The new responsibility will be added to the Health Responsibility History grid. The **Save** button enables.*
OR
Clicking on the **No** button to cancel the designation.
The rows in the Tracked Child grid and Responsible Agency List grids are de-selected.
- 5 Click on the **Save** button.
- 6 Click on the **Close** button.
The Health Services window displays.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Options menu > Designate
Health Responsibility command*



Step-by-Step: End Dating Agency Health Responsibility

- 1 In the Health Responsibility History grid, click on the space to the left to select the appropriate history record.
*The **End Responsibility** button enables.*
- 2 Click on the **End Responsibility** button.
The following message displays: “Current Responsibility will be ended. Do you wish to continue?”
- 3 Click on the **Yes** button to end responsibility.
*The **Responsibility End Date** field populates with today's date. The **Save** button enables.*
OR
Click on the **No** button to cancel.
The row in the Health Responsibility History grid is de-selected.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Options menu > Designate
Health Responsibility command*

- 4 Click on the **Save** button.
- 5 Click on the **Close** button.
The Health Services window displays.

Accessing the Health Services Window

The *Health Services* window provides you the ability to view, record, and/or modify health information. This window is accessed by clicking on the **Health Services** tab from the *Family Services Stage* window.

	Step-by-Step: Accessing the <i>Health Services</i> Window (With an assigned role in the CONNECTIONS stage or access to the assigned worker's Assigned Workload)
<ol style="list-style-type: none">1 Click on the WORK button on the CONNECTIONS Toolbar. <i>The Assigned Workload displays.</i>2 Select the appropriate FSS stage and click on the Tasks... button. <i>The Family Services Stage window displays.</i>3 Click on the Health Services tab. <i>The Health Services window displays.</i>	 <p>Workers within the Unit Hierarchy with Unit Summary access will also have access to the assigned worker's <i>Assigned Workload</i>.</p>
	 <p>The tabs on the <i>Health Services</i> window will not display until a child is selected.</p>

	Step-by-Step: Accessing the <i>Health Services</i> Window via a Case Search (for open and closed stages, without an assigned role in the stage, and assigned the MAINT HEALTH Business Function)
<ol style="list-style-type: none">1 Click on the CASE button on the CONNECTIONS Toolbar. <i>The Case Search Criteria window displays.</i>2 Enter the Case ID number in the Case ID field (or the Stage ID number in the Stage ID field). <i>The Search button enables.</i>3 Click on the Search button. <i>The Case List displays with the only case that matches the search criteria.</i>4 Select the case from the <i>Case List</i>. <i>The Summary button enables.</i>5 Click on the Summary button. <i>The Case Summary window displays.</i>	 <p>In addition to the MAINT HEALTH Business Function, workers need the Case or Person Search Business Function to access Health Services.</p>

- 6 Select the FSS stage from the *Case Summary* window.
- 7 Click on the **Options** menu, select the **Stage Maint.** menu item.
- 8 Select the **Maintain Health** command.
The Health Services window displays.



You can also search by Case Name; however, when searching by Case Name, the search criteria must exactly match the CONNECTIONS Case Name in order for the search to return a match. Other names in the Case Composition for that case will not return a match (e.g., if a case is named after Sandra Connors, her daughter Mary will be included in the Case Composition, but will not return a match if the Case Search uses Mary's name as the search criteria.



Step-by-Step:
Viewing the *Health Services* window
(with the VIEW HEALTH Business Function)

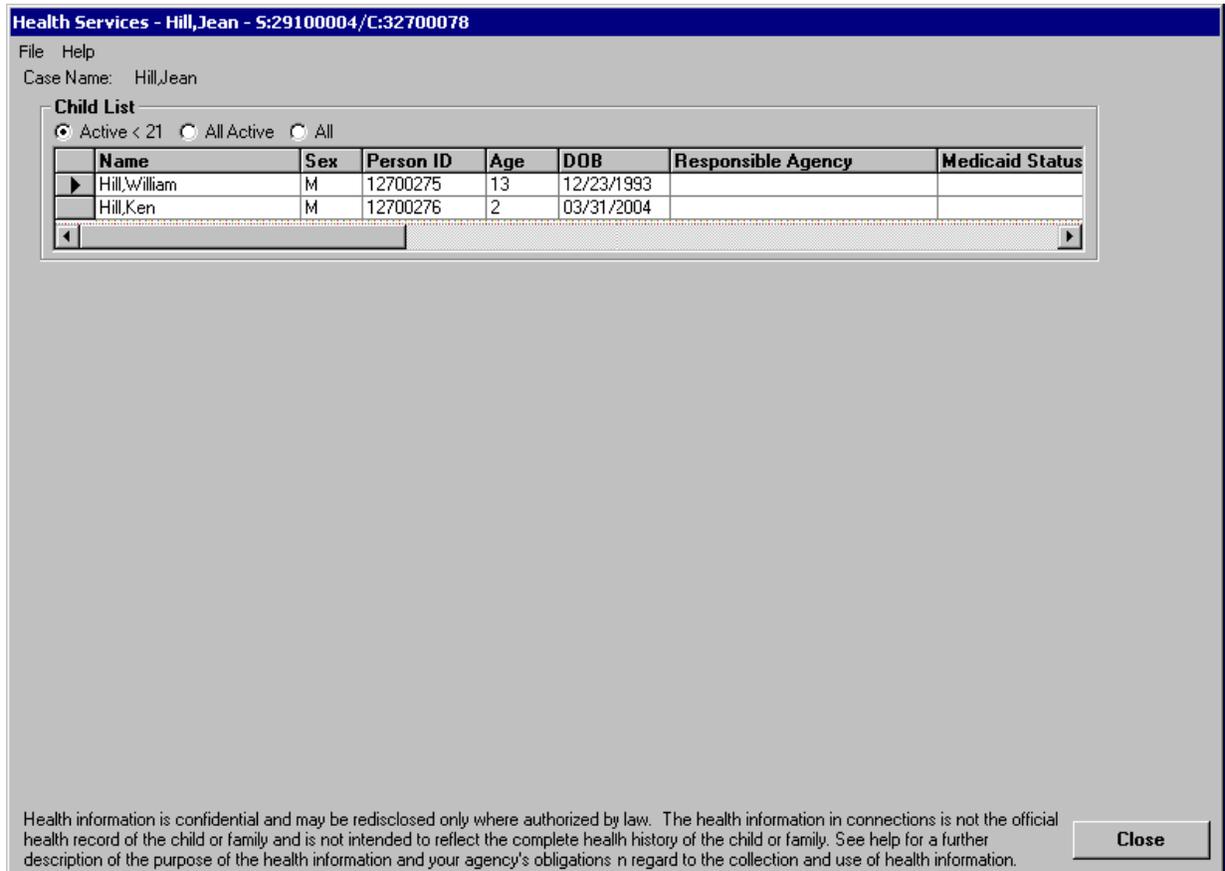
- 1 Click on the **CASE** button on the CONNECTIONS Toolbar.
The Case Search Criteria window displays.
- 2 Enter the Case ID number in the **Case ID** field (or the Stage ID number in the **Stage ID** field).
*The **Search** button enables.*
- 3 Click on the **Search** button.
The Case List displays with the only case that matches the search criteria.
- 4 Select the case from the *Case List*.
*The **Summary** button enables.*
- 5 Click on the **Summary** button.
The Case Summary window displays.
- 6 Select the Family Services Stages.
*The **Events** button enables.*
- 7 Click on the **Events** button.
The Event List displays for the selected stage.
- 8 Select the "Family Services Stage Opened" event from the *Event List*.
*The **Detail** button enables.*
- 9 Click on the **Detail** button.
The selected FSS displays.
- 10 Click on the **Health Services** tab.
The Health Services window opens.



Workers in an agency designated with health responsibility and the Business Function ACCESS ALL IN DISTRICT or ACCESS ALL IN AGENCY must be assigned the MAINT HEALTH or VIEW HEALTH Business Function in order to access health information in a Family Services Stage. Access to Health Information should be allowed only to those with an identifiable and supportable need to know.

The Health Services Window

The *Health Services* window is comprised of a header, footer, Child List grid, health tabs and buttons. The header contains the Case Name, as well as **File**, **Options**, **Reports** and **Help** menus. The footer contains a disclaimer and **Close** button, which is always enabled.



Child List Section

Upon entering the window, the default display of the Child List is “Active<21,” meaning only active children in the stage who are under 21 years of age will display in the grid. Selecting the **All Active** radio button populates the grid with all active individuals in the stage, while selecting the **All** radio button populates the grid with all active and end-dated individuals in the stage. The window is view-only when the **All** button is selected.

Individuals are listed in descending order by age, oldest to youngest; however, the sort order can be changed by clicking on a column heading (e.g., **Name**, **DOB**). The scroll bar displays to the right of the grid (when necessary), you can scroll down and view the entire list. Selecting a child from this list displays information specific for that child. Only one child may be selected at a time.

When a child is selected and has never had a Program Choice or Permanency Planning Goal (PPG) the following message displays:

“Person selected has never been tracked in this stage. Health Information is not available for viewing or updating.”

Additionally, when a child has a history of a Program Choice or PPG within the stage being accessed, but is not actively tracked within the stage, the following message displays when the signed on worker's agency has any historical responsibility for the child:

“Person selected is not actively tracked in this stage. You will be viewing information up until the date the track/responsibility was ended.”

If signed on worker's agency has no historical responsibility for the child the following message will display:

“No historical health responsibility for this person. Health Information is not available for viewing.”

The grid is comprised of the following columns:

Name	The child's name (Last, First, Middle Initial).
Sex	The child's gender.
Person ID	The child's unique, CONNECTIONS system-generated identification number.
Age	The child's age (computed using the child's date of birth and current system date).
DOB	The child's date of birth.
Responsible Agency	This field is populated with the name of the Agency designated to maintain health information. When a designation has not been made, this field is blank.
Medicaid Status	This field will not be supported until a future build.
FC	A checkmark indicates the child has a Program Choice of Placement (Foster Care).
EI	A checkmark indicates Early Intervention information has been recorded for the child.

The following additional columns display when the **All** radio button is selected:

Start Date	The date the person was first added to the stage.
End Date	This field represents the date the person was removed from the stage.
Gap	A checkmark in this column indicates that a person was present in a stage more than one time.

The selection of a child will display the tabs on the *Health Services* window. When you select a child with which your agency has no health responsibility, the following message will display:

“No health responsibility for this child. Health Information is not available for viewing/updating.”

In this case you will only have access to the **Early Intervention** tab.

The *Health Services* window consists of the following tabs:

- The **Child Health Info.** tab is designed as a summary snapshot of the child's Health Services information. An output of this information is available.
- In the **Clinical Appointments** tab, you can verify the completion of mandated and recommended health assessments. It also provides for recording diagnoses of chronic medical conditions.
- The **Early Intervention** tab should be used to record Early Intervention referrals that are required for all children under age three in an indicated CPS case and recommended for all foster children under age three. You can also record evaluation results, program information and the type of services a child receives.
- The **Bio. Family Health Info.** tab contains information to the extent known about hereditary conditions or diseases in the child's biological family as well as information that is specific to the pregnancy of the mother with the selected child.
- The **HIV Risk Assessment** tab provides for recording the HIV risk assessment which is required for all children placed in foster care. Additionally, workers will record information pertaining to the child's capacity to consent to HIV testing, the presence of risk factors, and test results, if applicable.
- The **Health Narrative** provides a place for recording confidential health information about the child that should not be recorded in Progress Notes.

The *Health Services* window contains the **Close** button; clicking on the **Close** button closes the window and returns you to the window from which you accessed Health Services. If any unsaved changes exist on the window when you click on this button, the following message displays:

*"Do you want to Exit?
Unsaved data and/or narrative(s) will be lost."*

- Clicking on the **Yes** button discards the unsaved changes and closes the window.
- Clicking on the **No** button closes the message without closing the window; all changes remain unsaved.

The following message display in the footer of **Clinical Appointment** tab:

"Add or Verify Health Provider Exists prior to entering Clinical Appointment."

Also located in the footer of the **Child Health Info.** and **Early Intervention** tabs is the following disclaimer:

"Health information is confidential and may be redisclosed only where authorized by law. The Health information in connections is not the official health record of the child and is not intended to reflect the complete health history of the child or family. See help for a further description of the health information and your agency's obligations in regard to the collection and use of health information."

Child Health Info. Tab

This tab is designed to act as an electronic “face sheet” for the child’s medical history. It will provide a summary of critical information, including allergies, current medications, durable medical equipment used by the child, and hospitalizations. Contact information for the child’s medical home and agency after-hours contact is also included on this tab. This tab will be most useful to the worker when the information on it is kept up-to-date.

You are required to record all *current* medication (including over-the-counter medications that are taken regularly), allergies and durable medical equipment information, in addition to the current medical home and after-hours contact information. The start dates for required information are mandated and may be estimated if an exact date is not known or unable to be verified.

When recording information on this tab you must save the information in each section separately before you can record information in another section of the tab.



All hospital admissions must be recorded for children in foster care on the **Child Health Info.** tab.



Step-by-Step: Accessing the Child Health Info Tab

- 1 On the Health Services window, select a child from the Child List grid.
*The **Child Health Info.** tab & all other tabs display.*

Health Services - Hill, Jean - S:29100001/C:32700178

File Options Reports Help
Case Name: Hill, Jean

Child List
 Active < 21 All Active All

Name	Sex	Person ID	Age	DOB	Responsible Agency	Medicaid Status
Hill, William	M	12700625	13	12/23/1993		
Hill, Ken	M	12700626	3	03/31/2004		

Child Health Info Clinical Appointment Early Intervention Bio. Family Health Info HIV Risk Assessment Health Narrative

Medications

Medication	Condition	Start Date	End Date	INV
DEPAKOTE	Bipolar Diso	07/05/2006		<input type="checkbox"/>

Allergies

Category	Allergen	Specify	Start Date	End Date	INV
Food	Cashews		05/01/2007		<input type="checkbox"/>
*					<input type="checkbox"/>

Durable Medical Equipment

Equipment	Specify	Start Date	End Date	INV
Eyeglasses (07/03/2007		<input type="checkbox"/>
*				<input type="checkbox"/>

Hospitalizations

Hospital	Psy	City/To	Reaso	Start Date	End Date	INV
St. Peter's	<input checked="" type="checkbox"/>	Albany	Observa	07/03/2006		<input type="checkbox"/>
*	<input type="checkbox"/>					<input type="checkbox"/>

After Hours Agency Health Contact
 Contact: on-call worker Number: (518) 555-5551

Primary Care/Medical Home
 Name: Number: () -

Primary Care / Medical Home Save Cancel

Health information is confidential and may be redisclosed only where authorized by law. The health information in connections is not the official health record of the child or family and is not intended to reflect the complete health history of the child or family. See help for a further description of the purpose of the health information and your agency's obligations in regard to the collection and use of health information. Close

The **Child Health Info** tab will contain various grids, sections and buttons. Most grids and sections have recordable fields. However, to record information for the **Medications** and **Primary Care/Medical Home** sections you must access another window. The **Child Health Info** tab is comprised of the following sections:

- Medications
- Allergies
- Durable Medical Equipment
- Hospitalizations
- After Hours Agency Health Contact
- Primary Care/Medical Home



All medical and mental health information about a child in foster care must be kept confidential in accordance with Social Services Law (section 372). Such information may be shared only with health practitioners, health staff, caseworkers, direct care workers, and foster and adoptive parents (with some exceptions) when they need it to provide adequate care and supervision. Refer to the Health Services Security topic for more details on health information confidentiality and security.

The window contains the following buttons:

- | | |
|---------------------------------------|--|
| Primary Care/
Medical Home | The Primary Care/Medical Home button opens the <i>Primary Care/Medical Home</i> window, which provides for viewing and selecting the Primary Care/Medical Home for a child. This button is enabled when a child is selected in the Child List and there are no unsaved changes on the Child Health Info tab. |
| Save | The Save button enables when required information is recorded. Clicking on this button saves modifications that have been made. If any required field is missing information a message will display. |
| Cancel | The Cancel button is disabled until a modification is made on the open window. Clicking on this button cancels any changes made to the information on the tab since the last save. The following message displays upon clicking on the Cancel button, |

*“Do you want to cancel?
Unsaved data and/or narrative(s) will be lost.”*

- Clicking on the **Yes** button discards the unsaved changes.
- Clicking on the **No** button leaves the window open; all changes remain pending.

Medications Section

The Medications section differs from other sections on this tab because the information will not be recorded directly in the Medications grid. The **Medication**, **Condition** and **Start Date** columns will be view-only and updated from the *Select Medications* window. The remaining columns (End Date & INV) are modifiable at any time once information is saved to the *Select Medications* window. Clicking on the **Medications** button opens the *Select Medication* window. On this window, you may search, record and save any medication information. After saving the required information, the **Child Health Info**. tab displays the recorded information.

The medications section consists of the following columns:

- | | |
|-------------------|---|
| Medication | The drug name selected on the <i>Select Medications</i> window. |
| Condition | This required field displays the condition recorded on the <i>Select Medications</i> window. |
| Start Date | The date on which the information is first applicable. This field is view-only and can be modified on the <i>Select Medications</i> window. The date recorded in this field cannot be earlier than the child's date of birth or a future date. |
| End Date | The date on which the information is no longer applicable. When medication information exists, a date may be recorded in this field. |
| INV | A checkmark in this field indicates the selected record was incorrectly recorded in CONNECTIONS. “Invalid” in CONNECTIONS typically means that the information was <i>never</i> correct—that it was recorded in error. When medication information exists, this field will be modifiable. Invalid entries will display at the bottom of the list and will not be included in any outputs. |

The Select Medications Window

This window provides for the recording of medications. This window features a search function enabling you to find medication names. The medication list is obtained from listings of the Food and Drug Administration, and will be updated on a quarterly basis.

Note:

- You may choose to enter historical medications. This can be extremely helpful if different psychotropic medications have been prescribed over a period of time or medications have not been well tolerated by the child.
- Medication dosages are not required to be recorded in CONNECTIONS. Dosages are recorded in the child's Medication Administration Record (MAR) as part of the complete medical file. Workers may record dosages in the Health Narrative to facilitate communication among the child's workers, but this is not required.
- Over-the-counter medications should be entered for chronic conditions or if taken on a regular basis.

The *Select Medications* window is comprised of work sections, a header and footer. The header contains the Child Name, as well as **File**, **Options** and **Help** menus. The footer contains the **Delete**, **Save** and **Cancel** buttons. Other buttons include the **Search** and **Clear** buttons.

The *Select Medications* window is divided into the following work sections: the *Search* section, the *Results* section & the *Medications grid* section. The **Enter the first 3 characters** and **Enter the exact drug name** fields will be enabled upon entering the *Select Medications* window. You can only enter text in one field in order to initiate a search. Once a search is complete, the Drug Name and Active Ingredients columns of the Results grid populate. If a drug cannot be located, the drug name is probably spelled incorrectly. This should be clarified with the source. To support accuracy when recording medications, the drug name should be copied carefully from the prescription bottle since there are many spelling similarities.



As many medications have similar spellings, it is best to have the prescription in hand when entering the medication. If this is not possible, copy the name carefully so the correct medication is selected.



Step-by-Step: Accessing the Select Medications Window

- 1 With a child selected on the Child List grid, click on the **Medications** button.
The Select Medications window displays.



Where am I?

Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Child Health
info. tab

Select Medications
File Options Help

Child Name: Hill,Kelly

Search
Select the medication from the list below. Search for the drug name by the exact name search or by the first 3 characters.

Enter the first 3 characters: Enter the exact drug name:

Results

Drug	Active Ingredient
DEPACON	VALPROATE SODIUM
DEPAKENE	VALPROIC ACID
▶ DEPAKOTE	DIVALPROEX SODIUM
DEPAKOTE CP	DIVALPROEX SODIUM
DEPAKOTE ER	DIVALPROEX SODIUM
DEPEN	PENICILLAMINE
DEPINAR	CYANOCOBALAMIN; TANNIC ACID; ZINC ACETATE
DEPOCYT	CYTARABINE

Medication	Condition	Start Date	End Date
▶ LITHIUM CARBONATE	bipolar disorder	03/06/2006	09/20/2006

The Results grid contains the following columns:

- Drug** The Drug column displays the name of the medication(s) that match the search criteria.
- Active Ingredients** The Active Ingredients column displays the active ingredients of the medication listed in the Drug column.

The Medications grid on this window is modifiable and can be saved to the database. The grid is comprised of the following columns:

- Medication** This field is populated upon selecting a drug name from the results grid and clicking on the **Add** button.
- Condition** Information must be recorded in this field after adding a medication. A maximum of 125 characters can be recorded. You should always ascertain the condition for which the medication has been prescribed in order to correctly complete this field.
- Start Date** The date on which the child first used the medication. The date recorded in this field cannot be earlier than the child's date of birth or a future date. This field is required upon adding a medication.

For start dates regarding medications, workers should use the following guidelines (use best judgment to approximate the start date as best as possible):

- Use the exact date, if known. For new prescriptions, use the date on the prescription bottle. If you only know the year, use January 1st of that year. If the formulation changes for an existing prescription, add a new record.
- If you only know the month and year, use the first day of the month.
- If the medication has been prescribed since birth, use the DOB.
- If you only know the child's age when the medication was first prescribed, use the child's birthday.
- For medications taken for a chronic condition, use the date the prescription began, not the refill date (even if the dosage has changed). Use the exact date, if known. For new prescriptions, use the date on the prescription bottle.

End Date The date on which the medication was discontinued by the child. When medication information exists, a date may be recorded in this field.

The window contains the following buttons:

Search The **Search** button enables when information is recorded in either search field. This button performs a search, displaying all records that match the search criteria.

Clear This button clears existing information in the drug search field and Results grid. It enables when text is recorded in a search field.

Add The **Add** button enables when a drug has been selected in the Results grid. Clicking on this button adds a selected medication to the Medications grid.

Delete This button deletes the selected row on the grid prior to saving the record to the database.

Save The **Save** button enables when a drug has been added to the Medications grid. Clicking on this button saves modifications that have been made. Once changes are saved, the *Health Services* window displays. If any required field is missing information the following message displays:

“Condition Treated and Start Date are required.”

- Click on the **OK** button to return to the window and record required information.

Cancel The **Cancel** button is disabled until a modification is made on the open window. Clicking on this button cancels any changes made to the information on the tab since the last save. The following message displays upon clicking on the **Cancel** button:

*“Do you want to cancel?
Unsaved data and/or narrative(s) will be lost.”*

- Clicking on the **Yes** button discards the unsaved changes.
- Clicking on the **No** button leaves the window open; all changes remain pending.



Step-by-Step: Recording Medications on the Select Medications Window

- 1 On the *Select Medications* window, in one of the search fields, record the first three characters or the entire drug name.
*The **Search** button enables.*
- 2 Click on the **Search** button.
*A list of results display. The **Add** button enables.*
- 3 Click on the space to left to select the drug name from the Results grid.
- 4 Click on the **Add** button.
*The drug name is added to the Medications grid, and the search results are cleared. The **Condition** and **Start Date** columns enable.*
- 5 Click in the **Condition** field and record the health condition for which the medication has been prescribed.
*Use the same diagnosis that was recorded on the *Clinical Appointment* tab, if possible.*
- 6 Click in the **Start Date** field and record the date the child began taking the medication.
*The **Save** button enables.*
- 7 Click on the **Save** button.
*The **Child Health Info.** tab displays.*



Where am I?

Assigned Workload > FSS > Tasks > Health Services tab> Select a Child > Child Health info. tab> Medication button



Click the **Clear** button to remove any text in the search fields so you can perform another search.



Prior to saving a medication record it can be deleted by selecting the un-saved record and clicking on the **Delete** button.

The Allergies Section

The information in the next few sections are recorded directly on the tab, either by typing in the field, or selecting an item from a drop-down list generated by CONNECTIONS. The Allergies section provides for recording all current allergies. This information is very useful when kept current. Moreover, when caregivers and other health providers are provided with the system output (Health Summary Report) they can prevent exposure to allergens which may cause a life-threatening reaction in the child.

The Allergies grid contains the following columns:

Category	This field contains a drop-down list of the Food, Environmental and Medication categories.
Allergen	This field consists of a drop-down list of allergens that corresponds to the category selected. The selection of "Other" is always available. For a detailed list of allergens refer to Appendix A.
Specify Other	This is a required text field when "Other" is selected from the Allergen column.

Start Date The date on which the allergy was first identified. The date recorded in this field cannot be earlier than the child's date of birth or a future date.

For start dates regarding allergies, workers should use the following guidelines (use best judgment to approximate the start date as best as possible):

- Use the exact date the allergy was first identified, if known.
- If you only know the year, use January 1st of that year.
- If you only know the month and year, use the first day of the month.
- If the allergy has been present since birth, use the DOB.
- If you only know the child's age when the allergy was identified, use the child's birthday.

End Date The date on which the child was determined to no longer have the identified allergy.

INV A checkmark in this field indicates the selected record was incorrectly recorded in CONNECTIONS. "Invalid" in CONNECTIONS typically means that the information was *never* correct—that it was recorded in error. Invalid entries will fall to the bottom of the list and will not be included in any outputs.



To end-date or invalidate a record, refer to the End-Dating and Invalidating section for Step by Step instructions on Page 36.



Step-by-Step: Recording Allergies

- 1 With a child selected in the Child List grid, click in the **Allergies** section.
- 2 Click on the Categories drop-down arrow and select the appropriate category.
*The **Save** button enables.*
- 3 Click on the drop-down to select the correct Allergen.
- 4 If "Other" is selected as the Allergen, record the specific allergen in the **Specify** field.
If "Other" was not selected as the Allergen, skip to Step #5.
- 5 Click in the **Start Date** field and record the date.
- 6 Click on the **Save** button.
*All sections on the **Child Health info. tab** display.
If any required information is missing the following message displays: "Category, Allergen and Start Date are required."
Click on the **OK** button to continue and record the necessary information.*



Where am I?
Assigned Workload > FSS > Tasks > Health Services tab > Select a Child > Child Health info. tab

Durable Medical Equipment Section

This section provides for recording durable medical equipment/adaptive devices currently used or required by the child (e.g., wheelchair, feeding pump, glasses).

The grid is comprised of the following columns:

Equipment This field contains a drop-down list of medical equipment and adaptive devices. Refer to Appendix A for a complete list of equipment.

Specify Other This is a required text field when Other is selected from the **Equipment** column.

Start Date The date on which the equipment was first used. The date recorded in this field cannot be earlier than the child's date of birth or a future date.

For start dates regarding durable medical equipment, workers should use the following guidelines (use best judgment to approximate the start date as best as possible):

- Use the exact date, if known.
- If you only know the year, use January 1st of that year.
- If you only know the month and year, use the first day of the month.
- If the equipment has been used since birth, use the DOB.
- If you only know the child's age when the allergy was identified, use the child's birthday.

End Date The last date on which the child used the equipment.

INV A checkmark in this field indicates the selected record was incorrectly recorded in CONNECTIONS. "Invalid" in CONNECTIONS typically means that the information was *never* correct—that it was recorded in error. Invalid entries will fall to the bottom of the list and will not be included in any outputs.



To end-date or invalidate a record, refer to the End-Dating and Invalidating section for Step by Step instructions on Page 36.



Step-by-Step: Recording Durable Medical Equipment

- 1 With a child selected in the Child List grid, click in the Durable Medical Equipment section.
- 2 Click on the drop-down arrow in the **Equipment** column to select the equipment.
*The **Save** button enables.*
- 3 If "Other" is selected as the **Equipment**, record the specific equipment or adaptive device in the Specify Other field.
*All others proceed to **Step 4**.*



Where am I?
Assigned Workload > FSS > Tasks > Health Services tab > Select a Child > Child Health info. tab

4 Click in the **Start Date** field and select the date.

5 Click on the **Save** button.

*All sections on the **Child Health info. tab** display. If any required information is missing the following message displays: “Equipment and Start Date are required.” Click on the **OK** button to continue and record the necessary information to save.*

Hospitalizations Section

The information in the Hospitalizations grid is recorded directly on the **Child Health Info.** tab, either by typing in the field, or selecting an item from a drop-down list generated by CONNECTIONS. In this grid, you must record any overnight hospitalizations (admissions) while the child is in foster care and any overnight hospitalizations that occurred prior to foster care related to chronic health conditions or conditions that led to the child’s removal. If desired, any hospitalization can be recorded.

You are required to record:

- the name of the hospital;
- the city in which it is located;
- the reason for the hospitalization; and
- the hospitalization’s start date (and end date, if appropriate).

The grid contains the following columns:

Hospital	The name of the hospital in which the child was admitted.
Psy	A checkmark indicates psychiatric hospitalization.
City/Town	The name of the city or town in which the hospital is located.
Reason	The reason for the child’s admission.
Start Date	The date on which the child was admitted to the hospital. The date recorded in this field cannot be earlier than the child’s date of birth or a future date.
End Date	The date on which the child was discharged from the hospital.
INV	A checkmark in this field indicates the selected record was incorrectly recorded in CONNECTIONS. “Invalid” in CONNECTIONS typically means that the information was <i>never</i> correct—that it was recorded in error. Invalid entries will fall to the bottom of the list and will not be included in any outputs.



To end-date or invalidate a record, refer to the End-Dating and Invalidating section for Step by Step instructions on Page 36.



Step-by-Step: Recording Hospitalizations

- 1 With a child selected in the Child List grid, click in the **Hospital** field and record the Hospital name.
*The **Save** button enables.*
- 2 If appropriate, select the **Psy** checkbox to indicate a psychiatric hospitalization.
*The **Psy** checkbox populates.*
- 3 Click in the **City/Town** field and record the name.
- 4 Click the **Reason** field and record the reason the child was admitted.
- 5 Click in the **Start** field and select the desired date.
- 6 Click in the **End Date** field and select the desired date.
This should be completed once the child has been discharged from the hospital.
- 7 Click on the **Save** button.
*All sections on the **Child Health info.** tab display. If any required information is missing the following message displays: "Hospital, City/Town and Start Date are required."
Click on the **OK** button to continue and record the necessary information.*



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab>
Select a Child > Child Health
Info. tab*

After-Hours Agency Health Contact Section

This section provides for recording the name and number of an agency staff person or answering service to reach after business hours for medical emergencies. These fields are required and may be updated at any time. This information will display on the Health Summary output given to the child's foster parents so they know who to contact if there is a medical emergency.



Step-by-Step: Recording the After Hours Agency Health Contact

- 1 With a child selected in the Child List grid, click in the **Contact** field.
- 2 Record the name of the After Hours Agency Health Contact person or service in the **Contact** field.
*The **Save** button enables.*
- 3 Record the phone number (e.g. (999) 999-9999) in the **Number** field.
- 4 Click on the **Save** button.
*All sections on the **Child Health Info.** tab display.*



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab>
Select a Child > Child Health
Info. tab*

Primary Care/Medical Home Section

The Primary Care/Medical Home section will contain the Name and Number view-only fields. The information displayed will be pulled from the *Primary Care/Medical Home* pop-up window. This window can be accessed by clicking on the **Primary Care/Medical Home** button or by selecting the **Options** menu and clicking on the **Primary Care/Medical Home** command. This button is enabled when a child is selected in the Child List and there are no unsaved changes on the **Child Health Info** tab.

The window provides for viewing and selecting the Primary Care/Medical Home for a child. Upon entering the window, you will see a list of the health providers that were recorded on the **Clinical Appointment** tab. Clicking on the check box in the **Pr** column next to the name of the provider designates that provider as the Medical Home. That resource's contact information will then display on the **Child Health Info** tab.



Step-by-Step: Accessing the Primary Care/Medical Home Window

- 1 With a child selected in the Child List grid, click on the **Primary Care/Medical Home** button.
The Primary Care/Medical Home window displays.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child*

Primary Care/Medical Home - Hill,Kelly - P:28924523

File Help

	Pr	Resource	Street	PO Box/Apt	City	State	Zip	County	CD
	<input checked="" type="checkbox"/>	Albany Medical	240 WASHINGTO		ALBANY	NY	12210-131	ALBANY	

Save Cancel

Primary Care/ Medical Home Window

The *Primary Care/Medical Home* window will be comprised of a grid and buttons. The grid lists any previously saved health providers (stage-specific) and can be used to select a Primary Care/Medical Home. This information originates from what was recorded for a child on the **Clinical Appointment** tab.

The grid contains the following columns:

Pr	A checkmark in this column indicates the record is designated as the Primary Care/Medical Home. The Pr field is the only modifiable field on the <i>Primary Care/Medical Home</i> window.
Resource	This field contains the name of the medical facility or health provider.
Street	The field contains the street address of the medical facility or health provider.
PO Box/Apt	This field contains the post office box or apartment number for the medical facility or health provider.
City State Zip	The City, State and ZIP Code associated with the address.
County	The County field contains the county of the medical facility or health provider.
CD	This is the Community District code used only for New York City addresses.
Number and Extension	The telephone number and extension of the medical facility or health provider.

The *Primary Care/Medical Home* window contains the following buttons:

Save	The Save button enables when a change has been made on the window. Clicking on this button saves modifications that have been made. Once changes are saved, the Child Health Info tab displays.
Cancel	Clicking on this button closes the window and displays the Child Health Info tab. The following message displays when unsaved changes exist on the window:

“Do you want to cancel?”

Unsaved data and/or narrative(s) will be lost.”

- Clicking on the **Yes** button discards the unsaved changes.
- Clicking on the **No** button leaves the window open; all changes remain pending.



Step-by-Step: Recording the Primary Care/Medical Home

- 1 On the Primary Care/Medical Home window, click on the **Pr** checkbox to select a health provider as the Primary Care/Medical Home.
*The **Save** button enables.*
- 2 Click on the **Save** button.
*The **Child Health Info** tab displays with the selected health provider information populated in the Primary Care/Medical Home section.*



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Primary
Care/Medical Home button*

End-Dating or Invalidating Information on the Child Health Info. Tab

The End Date functionality is used to indicate that the record is no longer applicable while maintaining an historical record. With the exception of the **End Date** and **INV** fields, all fields in the Medications, Allergies, Durable Medical Equipment and Hospitalizations sections will be non-modifiable once saved.

A record may be marked invalid if it was recorded in error and the information was *never* correct. For the Allergies, Durable Medical Equipment and Hospitalizations sections, the **INV** checkbox is disabled when adding records to the grid. After invalidating a record the **End Date** field populates with the system date. This process preserves an historical record of the child's critical medical information.



Step-by-Step: End-Dating Information on the Child Health Info Tab

- 1 With a child selected in the Child List grid, click in the **End Date** field for a record in one of the following sections: Medications, Allergies, Durable Medical Equipment or Hospitalizations and record the date.
*The **Save** button enables.*
- 2 Record the end date for the record that is no longer applicable.
*The date displays in the **End-Date** field.*
- 3 Click on the **Save** button.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab>
Select a Child > Child Health
Info. tab*



Step-by-Step: Invalidating Information on the Child Health Info Tab

- 1 With a child selected in the Child List grid, click on the **INV** checkbox for one of the following sections: Medications, Allergies, Durable Medical Equipment or Hospitalizations to invalidate the record.
*A checkmark displays. The **End Date** field populates with the system date, unless an end-date was previously recorded for the same record.*
- 2 Click on the **Save** button.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab>
Select a Child > Child Health
Info. tab*

The Clinical Appointment Tab

The **Clinical Appointment** tab documents the completion of the initial comprehensive health evaluation required for all foster children. You can enter additional appointments, but it is not required. This evaluation consists of assessments in each of the five health domains (Dental, Developmental, Mental Health, Physical/Medical, and Substance Abuse), as age-appropriate. Additionally, the tab provides for recording the date of the clinical appointment, the provider, the health domain and type of appointment, and any diagnoses or treatment recommendations, including diagnoses of chronic health conditions.

Some of the information you will receive during your initial, pre-placement efforts to obtain historical health information about the child will be clinical appointment information: health service providers the child has seen in the past, the diagnoses they made, and the treatments they recommended. It is important to record the initial diagnosis of a chronic condition. This may be done using the appointment type “Diagnosis at Intake” if the diagnosis preceded the child’s entry into foster care and can be verified. You may enter all clinical appointments in this tab, but this is not required.



All medical and mental health information about a child in foster care must be kept confidential in accordance with Social Services Law (section 372). Such information may be shared only with health practitioners, health staff, caseworkers, direct care workers, and foster and adoptive parents (with some exceptions) when they need it to provide adequate care and supervision. Refer to the Health Services Security topic for more details on health information confidentiality and security.

The following required information is to be recorded on the **Clinical Appointment** tab:

- Initial Assessments in 5 domains (physical/medical, dental, developmental, mental health, and substance abuse for children 10 years of age and older) for children entering foster care.
- Periodic well-child care (physical/medical).
- Periodic preventive care (dental).
- “Immunizations up to date” indicator for initial and well-child physical/medical appointments
- Discharge exam (use the “Well child” appointment type).
- The initial diagnosis of a chronic illness. If the chronic condition existed prior to foster care, use the “Diagnosis at Intake” appointment type.
- All emergency and crisis intervention appointments.

To enter accurate data into CONNECTIONS, you should have the actual clinician’s note or exam record in hand when you begin recording this information in CONNECTIONS. If anything needs to be clarified, you should contact the clinician.



Step-by-Step: Accessing the Clinical Appointment Tab

- 1 On the Health Services window, select a child from the Child List.
*The **Child Health Info.** tab displays.*
- 2 Click on the **Clinical Appointment** tab.
*The **Clinical Appointment** tab displays.*



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child*

Health Services - Hill, Jean - S:29100001/C:32700178

File Options Reports Help
Case Name: Hill, Jean

Child List
 Active < 21 All Active All

Name	Sex	Person ID	Age	DOB	Responsible Agency	Medicaid Status
Hill, William	M	12700625	13	12/23/1993		
Hill, Ken	M	12700626	3	03/31/2004		

Child Health Info **Clinical Appointment** Early Intervention Bio. Family Health Info HIV Risk Assessment Health Narrative

History

App. Date	Domain Type	App. Type	Diagnosis Date	Provider	City/Town	Tx Rec	INV
11/05/2007	Physical/Medical	Initial Assessment		Dr Smith	ALBANY	<input type="checkbox"/>	<input type="checkbox"/>

Domain Type
 Dental
 Developmental
 Mental Health
 Physical/Medical
 Substance Abuse

Appointment Type

*** Diagnosis**

Diagnosis	End Date

Immunizations:
Are child's immunizations up to date? Yes No

Appointment Date:

Other

Add or Verify Health Provider Exists prior to entering Clinical Appointment

The **Clinical Appointment** tab will contain various grids, sections and buttons. The History grid, located at the top of the tab, displays any clinical appointment saved for the child in this stage. The appointment information will be listed in descending chronological order by appointment date and diagnosis date and can be sorted by clicking the appropriate column heading. Upon selecting a record, the grid will populate the corresponding fields on the bottom of the tab.

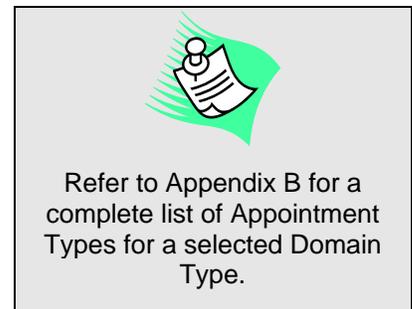
The grid consists of the following view-only columns:

App. Date	This field displays the date of the appointment.
Domain Type	This field indicates the type (e.g. Dental) of appointment.
App. Type	This field indicates the kind of appointment (e.g. Initial Assessment).
Diagnosis Date	The date the diagnosis was provided.
Provider	This field indicates the name of the health provider that rendered services.
City/Town	This column is for the name of the city or town in which the medical facility or health provider is located.
Tx Rec	A checkmark indicates that a treatment recommendation has been recorded.
INV	A checkmark in this field indicates the selected record was incorrectly recorded in CONNECTIONS. “Invalid” in CONNECTIONS typically means that the information was <i>never</i> correct—that it was recorded in error. Invalid entries will fall to the bottom of the list and will not be included in any outputs.

The Domain Type section includes five primary selections (Dental, Developmental, Mental Health, Physical/Medical, and Substance Abuse) which correspond to the five health assessment areas. In some cases a combination of domain types will need to be selected to record a clinical appointment. For example, well-child appointments for infants routinely deal with both physical/medical and developmental domains. For any combination of selected domain types, "Multiple" displays in the Domain Type field. Once a domain type is selected, the **Appointment Type** field enables and a selection is required.

Appointment Type

Once a **Domain Type** is selected, CONNECTIONS system populates the **Appointment Type** field. This field is required to be completed to save an appointment. Depending on the domain type selection, the **Appointment Type** field includes the following:



Crisis Intervention	An unscheduled intervention to respond to a child’s mental health, behavioral or substance use related crisis. This Appointment Type is available for Substance Abuse and Mental Health Domain Types .
Diagnosis at Intake	An appointment which occurred before the child entered foster care and resulted in the diagnosis of a chronic health condition. When “Diagnosis at Intake” is selected the field label Appointment Date changes to Diagnosis Date . This Appointment Type is available for any Domain Types selected.
Emergency care	An unscheduled appointment to address an urgent medical need; this includes a visit to an emergency room or urgent care facility. If the child is admitted to the hospital, record the hospitalizations on the Child Health Info. tab rather than Clinical Appointments tab. This Appointment Type is available for the Physical/Medical and Dental Domain Types .

Follow-up	An appointment to monitor the course of an illness or condition. Examples include a re-check after completing a course of antibiotics, and medication management for psychotropic medication. This Appointment Type is available for any Domain Type selected.
Initial Assessment	A comprehensive evaluation conducted when a child enters foster care; this typically includes a history, observation of the child by the clinician, physical exam (medical and dental), and diagnostic tests. This Appointment Type is available for any Domain Type selected.
Preventive	A routine visit to assess dental and oral health and provide preventive care such as teeth cleaning and sealants. This Appointment Type is available for the Dental Domain Type .
Reassessment	An appointment similar to the initial assessment conducted at a later time. This Appointment Type is available for any Domain Type selected..
Sick Child	An appointment scheduled to address a current illness or symptom. This Appointment Type is available for the Physical/Medical Domain Type .
Treatment	An appointment where the child receives a specific therapy or procedure, such as mental health counseling, filling a cavity, or speech therapy. This Appointment Type is available for all Domain Types except Physical/Medical.
Well Child	Periodic appointments at specific ages to evaluate the child's overall health status, including immunizations, and to provide anticipatory guidance to the caregivers. Discharge exams are recorded as Well Child appointments. This Appointment Type is available for the Physical/Medical Domain Type .



See the Health Services Manual for information on Initial Assessment at www.ocfs.state.ny.us/main/sppd/health_services/manual.asp

The Diagnosis section contains the Diagnosis and End Date columns. This section will generate a system-populated list depending on the domain type selected. The End-Date column is non-modifiable and is recorded on the *All Diagnoses* window. Recording a response in this section is optional although once a diagnosis is recorded a treatment recommendation should be recorded. Also in this section, will be the **Other** checkbox and text field allowing a diagnosis not listed to be recorded.



Refer to Appendix B for a complete list of Diagnoses for a selected Domain Type.

The **Appointment Date/Diagnosis Date** field is required and provides for selecting a date using a date picker.

The Immunizations section contains **Yes** or **No** radio buttons which will enable and requires a response when a domain type of Physical/Medical is selected. The response to this question should be based on whether immunizations are up-to-date as a result of this appointment.

This **Clinical Appointment** tab contains the following buttons:

Treatment Recom.	This button provides access to the <i>Treatment Recommendations</i> window where you can record specific treatment recommendations. It enables when a diagnosis is recorded.
Diag. Summary	This button provides access to the <i>All Diagnoses</i> window which provides for viewing and end-dating any saved diagnosis. This button does not enable if there are unsaved changes on the Clinical Appointment tab.
Add	Clicking on this button adds a new clinical appointment to the tab. This button enables when all required fields are complete.
Modify	This button will update an existing history record.
Clear	This button will clear fields allowing for the entry of new information.
Select Health Provider	This button will access the <i>Clinical Appointments Health Provider</i> window which tracks all providers listed from clinical appointments. When the <i>Clinical Appointment Health Provider</i> window is accessed using this button, it can be used to link a provider to the clinical appointment; however, health provider information cannot be added or modified. Modifications to a health provider can be made on the Clinical Appointment Health Provider window only when it is accessed using the Add/Modify Prov. button on the window (or its corresponding Options menu command).
Add/Modify Prov.	The Add/Modify Health Prov. button will access the <i>Clinical Appointment Health Provider</i> window where you can add or modify information for the child's health providers. This button is enabled when there are no unsaved changes on the Clinical Appointment tab, and is disabled when a record is selected in the History grid.
Save	Clicking on this button saves work that has been recorded or modifications that have been made.
Cancel	This button only enables when you have unsaved changes on the window. Clicking on the Cancel button displays the following message: <p style="text-align: center;"><i>"Changes have not been saved. Do you want to Cancel?"</i></p> <ul style="list-style-type: none">• Click on the Yes button to close the window without saving the information.• Click on the No button to leave the window open; all changes remain pending.

Recording a Clinical Appointment

Recording a clinical appointment will involve several steps. When no diagnosis is selected and an **Appointment Type** of "Diagnosis at Intake" is not selected, the **Domain Type**, **Appointment Type**, and Appointment Date fields will be required to save the appointment. Once a diagnosis or "Diagnosis at Intake" is selected, treatment recommendations (see Recording/Modifying Treatment Recommendations for a Diagnosis) should be recorded.

It is best to record every health provider's information prior to adding the record; this makes the provider available for linking to an appointment. Health provider information can be added/modified when there are no unsaved changes on the **Clinical Appointment** tab by clicking **Add/Modify Health Prov.** button, which displays the *Clinical Appointment Health Provider* window (see Adding a Clinical Appointment Health Provider).



Step-by-Step: Recording a New Clinical Appointment

- 1 With a child selected from the Select Child grid on the **Clinical Appointment** tab, select the **Domain Type**.
The Appointment Type, Diagnosis & Appointment Date sections enable. When the selected domain type is Physical/Medical the Immunization section enables.
- 2 Select the **Appointment Type**.
The checkmark populates.
- 3 If provided in the clinician's report, select the proper **Diagnosis**.
*The **Treatment Recom.** button enables.*
*If no diagnosis is available skip to Step #5. If applicable, specify the diagnosis in the **Other** field.*
- 4 If applicable, click on the **Treatment Recom.** button.
*See Recording a Treatment Recommendation. If a diagnosis has been recorded and a treatment recommendation has not been recorded the following message displays when upon clicking the **Add** button:*
'One or more diagnoses have been selected without selecting the corresponding Treatment Recommendation. Continue?'
- 5 Record the appropriate date in the **Appointment Date** or **Diagnosis Date** field.
The selected date displays.
- 6 If enabled, select the appropriate choice for the **Immunization** field based on the child's immunization status at the completion of the appointment.
The selection displays.
- 7 Click on the **Add** button.
If you have not already added a Health Provider the following message displays:
"After saving this record you will not be permitted to add a Health Provider. Would you like to select a Health Provider?"
- 8 Click on the **Yes** button to add a health provider.
The Clinical Appointment Health Provider window displays.
OR
Click on the **No** button to save the record without a provider.
*The **Save** button enables. The Clinical Appointment is added to the grid. Proceed to Step 11.*



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Clinical
Appointment tab*



The **Appointment Date** field changes to **Diagnosis Date** when an Appointment Type **Diagnosis at Intake** is selected.

- 9 Select a health provider in the Resource List grid.
The health provider's information displays in the detail fields.
- 10 Click on the **OK** button.
*The **Clinical Appointment** tab displays.*
- 11 Click on the **Save** button.
All health tabs enable.

Modifying a Clinical Appointment

A clinical appointment may only be modified if a record has been added to the History grid on the Clinical Appointment tab, but has not been saved to the database.



Step-by-Step: Modifying a Clinical Appointment

- 12 In this **History** grid on the **Clinical Appointment** tab, click in a blank area to the left of an *unsaved* record to select the record.
The Domain Type, Immunizations, Appointment Type, Appointment Date, Diagnosis, and Treatment Recommendation sections populate with information from the existing record.
- 13 Record the changes in the appropriate sections.
*The **Modify** button enables.*
- 14 Click on the **Modify** button.
If a diagnosis and a treatment recommendation have been recorded, skip to Step 5.
*The **Save** button enables.*
If a diagnosis has been recorded but a treatment recommendation has not been recorded, the following message displays:

“One or more diagnosis has been selected without selecting a corresponding Treatment Recommendation. Continue?”
- 15 Click on the **No** button to record a treatment recommendation(s).
The Treatment Recommendations window displays. See Recording/Modifying Treatment Recommendations for more information.
—OR—
*Click on the **Yes** button to save the record without a treatment recommendation.*
*The **Save** button enables. The clinical appointment is added to the **History** grid.*
- 16 Click on the **Save** button.
All Health Services tabs enable.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Clinical
Appointment tab*

Recording a Clinical Appointment Using a History Record

CONNECTIONS provides a way to save time by copying an existing clinical appointment to use as a starting point for a new appointment. The health provider from the copied appointment is listed as the health provider in the new appointment.



Step-by-Step: Recording a Clinical Appointment Using a History Record

- 1 With a child selected from the Select Child Grid on the Clinical Appointment tab, select an existing history record.
The information populates the corresponding grids.
- 2 Record the changes in the **Domain Type** or **Appointment Type** or **Appointment Date** fields.
The following message displays: "You are about to copy this appointment. All diagnoses and treatment recommendations will be cleared. You must select appropriate diagnoses and treatment recommendations for the new record."
- 3 Click on the **OK** button to close the message.
- 4 Record any diagnosis(es) or treatment recommendation(s), as appropriate.
*The **Add** button enables.*
- 5 Click on the **Add** button.
*The record is added to the grid and the **Save** buttons enables.*
- 6 Click on the **Save** button.
All health tabs enable.



Where am I?

Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Clinical
Appointment tab

Recording Health Care Provider Information

This window allows you to view or record information identifying the health provider that the child visited for the related clinical appointment. This window provides for two functions and can be accessed in various ways. When accessed from the **Select Health Provider** button, the window is view-only and used to link a provider to the clinical appointment. When accessed from the **Add/Modify Prov.** button or the **Add/Modify Health Provider** command on the **Options** menu, the window is used to add or modify the health provider information.

When in the window in modify mode, you may record the name, address and phone information for multiple health providers. All providers recorded will populate in the *Primary Care/Medical Home* window.

Clinical Appointment Health Provider

File Options Help

Name: Hill, William Person ID: 28924474

Resource	Street	PO Box/Apt	City	State	Zip	County	CD	Number
▶ Albany Dental	789 MADISON AV		ALBANY	NY	12208	ALBANY		(518) 463
▶ Albany Psychiatri	75 NEW SCOTLA		ALBANY	NY	12208	ALBANY		(518) 443
▶ St Peter's Hospit	159 WOLF RD		ALBANY	NY	12205	ALBANY		(518) 523

Resource Address Information

Resource Name: Albany Medical

Address Information

Street: 240 WASHINGTON AVE

PO Box/Apt:

City: ALBANY State: New York

Zip: 12210-1312 County: ALBANY

CD:

Number: (518) 456-4321

Extension:

Validate

Add Modify Clear Save Cancel

This window is arranged in two main sections: the grid section at the top of the window and the detail section at the bottom of the window. The header consists of the **File**, **Options** and **Help** menus.

The *Clinical Appointment Health Provider* window grid contains of the following view-only columns:

- Resource** This field contains the name of the health provider or the medical facility.
- Street** The field contains the street address of the medical facility or health provider.
- PO Box/Apt** This field contains the post office box or apartment number for the medical facility or health provider.
- City State Zip** The City, State and ZIP Code associated with the address.
- County** The County field contains the county of the medical facility or health provider.
- CD** This is the Community District code used only for New York City addresses.
- Number and Extension** The medical facility or health provider's telephone number and extension.

The detail section contains recordable fields corresponding to the grid located at the top of the window. These fields are used to initiate the process of adding a health provider to the component.

The window contains the following buttons:

- | | |
|-----------------|--|
| Validate | Clicking on this button performs address validation to verify the address and to format it in accordance with current U.S. Postal Service standards. All addresses must be validated. |
| Add | This button enables once an address has been validated. Clicking on this button adds health provider information to the window;. |
| Modify | After selecting a row, and making a change in the Resource Address Information section, the Modify button enables; clicking on this button updates an existing record. |
| Clear | This button clears information in the Resource Address Information section allowing you to enter new information. |
| OK | Clicking on the OK button closes the <i>Clinical Appointment Health Provider</i> window; any information entered in this window is saved to the database when you click on the Save button on the Clinical Appointment tab. |
| Close | Clicking on this button closes the window and displays the <i>Health Services</i> window. If any unsaved changes exist on the window when you click on this button, the following message displays:
<p style="text-align: center;"><i>“Do you want to Exit?
Unsaved data and/or narrative(s) will be lost.”</i></p> <ul style="list-style-type: none">• Clicking on the Yes button discards the unsaved changes and closes the window.• Clicking on the No button closes the message without closing the window; all changes remain pending. |



Step-by-Step: Adding a Clinical Appointment Health Provider

- 1 From the **Clinical Appointment** tab, click on the **Add/Modify Prov.** button.
The Clinical Appointment Health Provider window displays.
- 2 In the **Resource Name** field record appropriate information.
- 3 Record the primary street address in the **Street** field.
- 4 Record the second line of the address in the **P.O. Box/Apt** field, if applicable.
- 5 Record the city in the **City** field.
- 6 Select the appropriate state by clicking on the drop-down arrow in the **State** field.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Clinical
Appointment tab*

- 7 Enter the ZIP Code of the court in the **Zip** field.
- 8 Validate the address by clicking on the **Validate** button.
The address validation window displays.
- 9 Click on the **Accept** button to accept the validated address.
Proceed to Step 10.

—OR—

Click on the **Reject** button to reject the validated address.
You must reenter an address and repeat Step 8 in order to save the record.

- 10 If available, record the telephone number in the **Number** field.
*The **Add** button enables.*
- 11 Click on the **Add** button.
*The record is added to the grid. The **Save** button enables.*
- 12 Click on the **Save** button.
*The **Clinical Appointment** tab displays.*



Step-by-Step: Modifying a Clinical Appointment Health Provider

- 1 From the **Clinical Appointment** tab, click on the **Add/Modify Prov.** button.
The Clinical Appointment Health Provider window displays.
- 2 Click on the blank space to the left to select a record.
- 3 Modify the appropriate information on the window.
*If you modify any address information, the **Validate** button enables; complete **Steps 4-5**. If you modify other information (and do not modify any address information), the **Modify** button enables; skip to **Step 6**.*
- 4 Validate the address by clicking on the **Validate** button.
The address validation window displays.
- 5 Click on the **Accept** button to accept the validated address.
OR
Click on the **Reject** button to reject the validated address.
*You must reenter an address and repeat **Step 5**.*
- 6 Click on the **Modify** button.
*The record is updated in the grid. The **Save** button enables.*
- 7 Click on the **Save** button.
- 8 Click on the **Cancel** button.
The Clinical Appointment tab displays.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Clinical
Appointment tab*



Step-by-Step: Linking a Health Provider to a Clinical Appointment

- 1 With a child selected in the Child List grid, enter all of the appropriate information for the clinical appointment.
- 2 Click on the **Select Health Provider** button.
The Clinical Appointment Health Provider window displays.
- 3 Select a health provider in the Resource List grid.
The health provider's information displays in the detail fields.
- 4 Click on the **OK** button.
The Clinical Appointment tab displays.



Where am I?

*Assigned Workload > Tasks >
Health Services tab > Clinical
Appointment tab*

Treatment Recommendations Window

This window provides the ability to select from a comprehensive list of Treatment Recommendations corresponding to the selected diagnoses for a child. For every diagnosis, one or more treatment recommendation may be recorded. The list of treatment recommendations to choose from will be dependent on the domain selected. Although recommended, CONNECTIONS does not require treatment recommendations to be entered for every diagnosis in order to save.



Refer to Appendix B for a complete list of Treatment Recommendations for a selected Domain Type.

Treatment Recommendations

File Help

Child Name: Hill, Kelly

Select Treatment Recommendations for each of the Selected Diagnosis:

Diagnosis	Treatment Recommendations	Other Recommendations
Cavities	<input type="checkbox"/> Bridge/Dentures	
	<input type="checkbox"/> Endodontics (root canal)	
	<input type="checkbox"/> Extraction (oral surgery)	
	<input checked="" type="checkbox"/> Fillings	
	<input type="checkbox"/> Orthodontia	
	<input type="checkbox"/> Prophylaxis (cleaning, fluoride)	
	<input type="checkbox"/> Sealants	
	<input type="checkbox"/> X-rays	
	<input type="checkbox"/> Other	

OK Cancel

The *Treatment Recommendation* window is divided into the **Diagnosis**, **Treatment Recommendations** and **Other Recommendations** columns. The information populated in these columns varies depending on the domain selected. Multiple treatments may be record for a single diagnosis. When “Other” is selected as a treatment recommendation, you must record information in the Other Recommendation column.



When a treatment recommendation is selected in error, click on the checkbox to remove the checkmark.

The window contains the following buttons:

- OK** Clicking on this button closes the *Treatment Recommendations* window; any information entered in this window is saved to the database when you click on the **Save** button on the **Clinical Appointment** tab.
- Cancel** If changes have not been saved when you click on the **Cancel** button, the following message displays:
“Changes have not been saved. Do you want to Cancel?”
- Click on the **Yes** button to close the window without saving the information.
 - Click on the **No** button to leave the window open; all changes remain pending



Step-by-Step: Recording/Modifying Treatment Recommendations for a Diagnosis

- 1 With a clinical appointment selected, click on the **Treatment Recom.** button.
The Treatment Recommendations window displays.
- 2 For a selected diagnosis, click on the Treatment Recommendation(s).
*The checkmark displays. The **OK** button enables. When “Other” is select the Other Recommendation field becomes required. This field must be completed prior to the **OK** button enabling.*
- 3 If necessary, record the treatment in the Other Recommendations field.
*The **OK** button enables. The following message displays when Other is selected and no Other Recommendation is recorded:
“Please specify Other Treatment Recommendation.”*
- 4 Click on the **OK** button.
The Clinical Appointment window displays.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Clinical
Appointment tab*



The **Treatment Recom.** button enables once one or more diagnosis is recorded on the Clinical Appointment tab.

All Diagnoses Window

This window provides for viewing a combined list of all diagnoses from every saved clinical appointment in this stage. In addition, you will be able to end-date a diagnosis. The *Treatment Recommendation* window may also be accessed from the *All Diagnoses* window.

Diagnoses are displayed in the All Diagnoses grid with the most recent diagnoses first based on the App. Date and Diagnosis Date. The grid populates with all diagnoses; however, invalidated records are not included in the display. The only modifiable field on this window is the End Date.

	App. Date	Domain Type	Diagnosis Date	Diagnosis	End Date
▶	09/20/2006	Dental		Cavities	
	09/13/2006	Physical/Medical		Well Child	
		Mental Health	03/06/2006	Bipolar Disorder	

The *All Diagnoses* window displays the Child's name and PID (Person Identifier) in the title bar. The menu bar contains the following commands: **File**, **Options** and **Help**.

This window contains a grid and buttons. The grid contains of the following columns:

- App. Date** The date of the appointment.
- Domain Type** This field indicates the type (i.e. Dental) of appointment.
- Diagnosis Date** The date the diagnosis was provided. This column is populated for Diagnosis at Intake appointment types.
- Diagnosis** The recorded diagnosis for a child.
- End Date** The date on which the information is no longer applicable.

The window consists of the following buttons:

- | | |
|-------------------------|---|
| Treatment Recom. | This button provides view-only access to the <i>Treatment Recommendations</i> window for a selected diagnosis. |
| Save | Clicking on this button saves work that has been recorded or modifications that have been made. |
| Cancel | This button only enables when you have unsaved changes on the window. Clicking on the Cancel button displays the following message:
<p style="text-align: center;"><i>“Changes have not been saved. Do you want to Cancel?”</i></p> <ul style="list-style-type: none">• Click on the Yes button to close the window without saving the information.• Click on the No button to leave the window open; all changes remain pending. |
| Close | Clicking on this button closes the window and returns you to the <i>Clinical Appointments</i> tab. If any unsaved changes exist on the window when you click on this button, the following message displays:
<p style="text-align: center;"><i>“Do you want to Exit? Unsaved data and/or narrative(s) will be lost.”</i></p> <ul style="list-style-type: none">• Clicking on the Yes button discards the unsaved changes and closes the window.• Clicking on the No button closes the message without closing the window; all changes remain unsaved. |



Step-by-Step: Viewing a Child’s Diagnosis Summary/Treatment Recommendations

- 1** On the **Clinical Appointments** tab, click on the **Diag. Summary** button.
The All Diagnoses window displays.
- 2** Click on the space to the left to select the diagnosis record.
*The **Treatment Recom** button enables.*
- 3** Click on the **Treatment Recom** button.
The Treatment Recommendations window displays (view-only) for the selected diagnosis.
- 4** Click on the **Cancel** button.
The All Diagnoses window displays.
- 5** Click on the **Close** button.
*The **Clinical Appointment** tab displays.*



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Clinical
Appointment tab*



To view the Treatment Recommendation window you must be recording or viewing a clinical appointment record containing a diagnosis.

End-Dating a Diagnosis

The Diagnosis grid contains a list of system populated diagnoses and an end date column for the associated diagnosis. Once an end date is recorded and saved it will display in the Diagnosis section on the **Clinical Appointments** tab.



Step-by-Step: End-dating a Diagnosis on the All Diagnoses Window

- 1 On the *All Diagnoses* window, click on the **End Date** for the appropriate diagnosis field to record the date.
*The **Save** button enables.*
- 2 Click on the **Save** button.
The date is saved to the database.
- 3 Click on the **Close** button.
*The **Clinical Appointment** tab displays.*



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Clinical
Appointment tab > Diag.
Summary button*

Invalidating a Clinical Appointment Record

Records on the History grid may be invalidated by clicking on the INV checkbox. The following message will display when a record is invalidated:

“Invalidating this clinical appointment will end date any associated diagnoses. Do you wish to continue?”

Selecting the **Yes** button closes the message and marks the record as Invalid. The end-date field is also populated with the system date if a date was not recorded prior to invalidating the record. When an end date exists and the record is invalidated, CONNECTIONS will not update the end dated field with the current system date. Clicking on the **No** button deselects the INV checkbox.



Step-by-Step: Invalidating a Clinical Appointment Record

- 1 With a child selected in the Child List grid, click on the INV checkbox for the desired record in the History grid.
The following message displays: “Invalidating this clinical appointment will end date any associated diagnoses. Do you wish to continue?”
- 2 Click on the **Yes** button to invalidate the clinical appointment.
*The **INV** field populates with a checkmark. The **Save** button enables.*
OR
Click on the **No** button to cancel the invalidation.
The message closes and the INV checkbox is unchecked.
- 3 Click on the **Save** button.
All tabs on the Health Services window enable.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Clinical
Appointment tab*



Step-by-Step: Viewing an Existing Clinical Appointment

- 1 With a child selected in the Child List grid, click on the **Clinical Appointment** tab.
- 2 In this History grid, click in a blank area to the left to select the record.
*The Domain Type, Immunizations, Appointment Type, Appointment Date, Diagnosis, Treatment Recommendation sections populate with information from the existing record. When the **Tx** checkbox is checked, the **Treatment Recom.** button enables. If the record does not have a treatment recommendation proceed to **Step 5**.*
- 3 Click on the **Treatment Recom.** button.
The Treatment Recommendations window displays.
- 4 Click on the **Cancel** button.
*The **Clinical Appointments** tab displays.*
- 5 Click on the **Clear** button.
The populated areas of the Domain Type, Immunizations, Appointment Type, Appointment Date, Diagnosis, Treatment Recommendation sections clear.



Where am I?

Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Clinical
Appointment tab

The Early Intervention Program

The Early Intervention Program (EIP) is a voluntary program offering a variety of therapeutic and support services to eligible infants and toddlers and their families. Each county has an Early Intervention Officer/Designee (EIO/D) that oversees the provision of this in-depth, multi-disciplinary assessment and delivery of the Individualized Family Service Plan (IFSP) process.

Referral, assessment and documentation procedures for EIP treatment differ from care that results from the routine developmental assessment that is a part of the child's initial Comprehensive Health Evaluation. There are additional mandates regarding referrals to EIP.

Referral to EIP is mandated for:

- all children under three years of age in an Indicated CPS report;

Referral to EIP is recommended for:

- foster children under the age of three, particularly those children whose developmental assessments indicate the possibility of a developmental disability or delay; and
- any child under the age of three in a family receiving child welfare services from an agency or local district, if there is a reason to believe the child may be developmentally delayed or in danger of becoming developmentally delayed.

The New York State Department of Health is the lead agency for the Early Intervention Program.

A worker will have *two working days* from the time you determined a referral is necessary to make a referral.

Security for the Early Intervention Tab

Enhanced security associated with other modules in health does not apply to the **Early Intervention** tab. Instead, all workers with a role in the stage and health professionals with the MAINT HEALTH will be able to access the **Early Intervention** tab (view and modify). Additionally, health professionals with VIEW HEALTH Business Function and workers with an implied role in the case have view access to **Early Intervention** tab.

Early Intervention information can be recorded and modified for children until they reach their fourth birthday. After that date, Early Intervention information will be view-only.



All medical and mental health information about a child in foster care must be kept confidential in accordance with Social Services Law (section 372). Such information may be shared only with health practitioners, health staff, caseworkers, direct care workers, and foster and adoptive parents (with some exceptions) when they need it to provide adequate care and supervision. Refer to the Health Services Security topic for more details on health information confidentiality and security.



Refer to Local Commissioners Memorandum (LCM) 04-OCFS-LCM-04 for more information on Early Intervention standards and procedures when referring a child that is the subject of an indicated report of child abuse or maltreatment.



Refer to Appendix D of the Health Services Manual for a detailed protocol on the Early Intervention Program ("Children in Foster Care Who Participate in the Early Intervention Program") at:
www.ocfs.state.ny.us/main/sppd/health_services/manual.asp



Step-by-Step: Accessing the Early Intervention Tab

- 1 On the Health Services window, select a child from the Child List.
*The **Early Intervention** tab displays.*
- 2 Click on the **Early Intervention** tab.
*The **Early Invention** tab displays. The following message displays when a child over the age four is selected: "Early Intervention Information may not be entered for children over 4 years of age."*
Click on the **OK** button.



Where am I?

Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Early
Intervention. tab.

Health Services - Hill, Jean - 5:23846537/C:21974770

File Options Reports Help
Case Name: Hill, Jean

Child List:
 Active < 21 All Active All

Name	Sex	Person ID	Age	DOB	Responsible Agency	Medicaid Sta
Hill, William	M	28924474	8	12/23/1997	Albany County Dss	
Hill, Megan	F	28924524	2	10/07/2004	Albany County Dss	

Child Health Info Clinical Appointment **Early Intervention** Bio. Family Health Info. HIV Risk Assessment Health Narrative

Early Intervention Evaluation
 Referral Date: 09/08/2006 Classification/Disability Type: Disability Developmental Delay None
 Evaluation Date: 09/22/2006

History

Start Date	End Date	Program Name	Contact Person	Contact Number	Date Updated	Updated By	INV
3/25/2005	09/25/2005	Bright Horizons	Abigail Smith	(518) 555-7890	12/13/2006	Wilson, Darryl	<input type="checkbox"/>

Program Information
 Program Name: P's & Q's
 Program Contact Person: Frank Lloyd
 Contact Number: (518) 555-6789 Start Date: 09/25/2006

Service Types

Service Types	Receiving	Anticipated
Assistive Technology	<input type="checkbox"/>	<input type="checkbox"/>
Audiology Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family Training / Counseling	<input type="checkbox"/>	<input type="checkbox"/>
Health Services	<input type="checkbox"/>	<input type="checkbox"/>

Clear Save Cancel

Health information is confidential and may be redisclosed only where authorized by law. The health information in connections is not the official health record of the child or family and is not intended to reflect the complete health history of the child or family. See help for a further description of the purpose of the health information and your agency's obligations in regard to the collection and use of health information.

Close

The Early Intervention Tab

The **Early Intervention** tab provides for documenting the Early Intervention referral, the evaluation date and result, the service provider, and the type of services the child is receiving, as applicable. All applicable fields on the Early Intervention tab should be completed for a referred child. A completed Early Intervention evaluation should also be entered in the **Clinical Appointment** tab as a developmental assessment.

The **Early Intervention** tab is comprised of various fields, a History grid and buttons. This tab provides for recording Early Intervention information and viewing a child's Early Intervention records in both a summary and detail view with add, invalidate and print commands.

This tab contains an Early Intervention Evaluation area with two date pickers where you may enter the selected child's Referral Date and Evaluation Date. The Early Intervention area also contains three radio buttons where you may select one of the following:

- Disability
- Developmental Delay
- None

The History grid maintains a summary view of each Early Intervention Program that the child has attended. When you select a record in the History grid, the detailed Early Intervention Program information populates the other areas of the tab. The only columns that are editable in the History grid are End Date and the **INV** (Invalid) checkbox indicator. The History grid includes the following columns:

Start Date	The date on which the child began to receive services with the Early Intervention Program.
End Date	The date on which services in the Early Intervention Program ended for the child.
Program Name	The name of the program providing Early Intervention services.
Contact Person	A name of a contact person for the Early Intervention Service provider.
Contact Number	The telephone number for the provider of service.
Date Updated	This field is populated with date CONNECTIONS last saved information.
Updated By	This field is populated with the name of the worker who last saved information.
INV	A checkmark in this field indicates the selected record was incorrectly recorded in CONNECTIONS. "Invalid" in CONNECTIONS typically means that the information was <i>never</i> correct—that it was recorded in error. Invalid entries will display at the bottom of the list and will not be included in any outputs.

The Program information area is where you will record information about the specific Early Intervention Program serving the child. It includes fields for the Program Name, Program Contact Person and Contact Number. You will enter the Start Date that the child entered the Early Intervention Program in the Program Information area.

The Services Types area is where you will select the types of Service that the child is receiving or it is anticipated that they will be receiving. This area contains a list of Service Types and two mutually exclusive checkboxes indicators next to each listed service. The first checkbox is labeled “Receiving” and the second checkbox is labeled “Anticipated”. The Service Types section includes the following:

- Assistive Technology
- Audiology Services
- Family Training / Counseling
- Health Services
- Home Visits
- Nursing Services
- Nutritional Services
- Occupational Therapy
- Parent Support Groups
- Physical Therapy
- Psychological Services
- Service Coordination
- Special Instruction
- Speech-language Pathology Therapy
- Social Work Services
- Transportation Services
- Vision Services

The following buttons display at the bottom of the **Early Intervention** tab:

- | | |
|---------------|---|
| Clear | This button enables when an entry is recorded in the Program Information section. Clicking on the Clear button deletes information that is recorded prior to saving the record. |
| Save | Clicking on this button saves work that has been recorded or modifications that have been made. |
| Cancel | This button only enables when you have unsaved changes on the window. Clicking on the Cancel button displays the following message:
<i>“Changes have not been saved. Do you want to Cancel?”</i> <ul style="list-style-type: none">• Click on the Yes button to close the window without saving the information.• Click on the No button to leave the window open; all changes remain pending. |
| Close | Clicking on this button closes the window and displays the last window from which you originated. If any unsaved changes exist on the window when you click on this button, the following message displays:
<i>“Do you want to Exit?
Unsaved data and/or narrative(s) will be lost.”</i> <ul style="list-style-type: none">• Clicking on the Yes button discards the unsaved changes and closes the window.• Clicking on the No button closes the message without closing the window; all changes remain pending. |

Recording a New Early Intervention Record

Early Intervention records may be added for children up to the age of three years. When you select a child from the child list who is over four years of age the following message is displayed:

“Early Intervention Information may not be entered for children over 4 years of age.”

An **OK** button will display and once selected, it will close the message box.



Step-by-Step: Recording a New Early Intervention Record

- 1 Click on the **Early Intervention** tab.
The Early Intervention window displays.
- 2 Record the **Referral Date** in the Early Intervention Evaluation area.
*The **Save** button enables. You may save the record at this point since all children referred will not receive EI evaluations, and there may be a long wait between referral and evaluation. If additional information needs to be recorded proceed to **Step 4**.*
- 3 Click on the **Save** button.
The Referral Date is saved to the database.
- 4 Record the **Evaluation Date** in the Early Intervention Evaluation area.
- 5 In the **Classified/Disability Type** area click in the radio button to select the appropriate classification determined as a result of the evaluation.
- 6 Record the date the child entered the Early Intervention Program in the **Start Date** field.
*The **Save** button enables.*
- 7 Record the name of the Early Intervention Program in the **Program Name** field.
- 8 Record the name of the Early Intervention Program Contact Person.
- 9 In the **Contact Number** field record the telephone number of the contact person.
- 10 Select one or more **Service Types** in the **Service Types** area indicating if the service is currently being received or is anticipated.
- 11 Click on the **Save** button to save.
*A new Early Intervention Program record will be posted to the History grid and all previously recorded information in the Program Information and Service Types areas will be cleared.
The EI checkbox indicator on the Health Services window will be checked by the system.*



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child*



The date selected for the **Referral Date** or **Evaluation Date** fields may not be earlier than the child's DOB. If the evaluation takes place over multiple days, record the first day as the Evaluation Date.



If the evaluation takes place over multiple days, record the first day as the Evaluation Date.

Viewing an Early Intervention Record

You can view a child's Early Intervention records in both a summary and detail view by selecting a child in the Select Child grid from the Health Services window and selecting the Early Intervention tab. If information has been recorded in CONNECTIONS the History grid will contain a summary view of each Early Intervention Program that the child has attended.

The current record will appear at the top of the grid with the rest of the records in descending order. When you select a record in the History grid, the detailed Early Intervention Program information, Program Dates and Service Types populates the fields below. Invalid records display at the bottom of the grid.



Step-by-Step: Viewing an Early Intervention Record

- 1 Click on the **Early Intervention** tab.
The Early Intervention window displays.
- 2 Select the **desired record** in the History grid.
The Program Information and Services Types grids will be populated.
*The **Clear** button becomes enabled.*
- 3 Click on the **Clear** button.
The Program Information and Services Types grids will be cleared.



Where am I?

*Assigned Workload > FSS >
Tasks >Health Services tab>
Select a Child > Early
Intervention tab.*

End Dating and Invalidating an Existing Early Intervention Record

An Early Intervention record may be end dated or invalidated in the History grid. Pre-existing Early Intervention records for children over the age of four years may be end dated or invalidated as well. The End Date for an Early Intervention Program will be recorded in the End Date area of the History grid. CONNECTIONS will system-populate the **End-Date** field after a record has been invalidated. An Early Intervention Program record should be invalidated if it was never correct and should not have been recorded. For example, if the wrong child was selected when recording the Early Intervention Program, that record was never correct.



Step-by-Step: End Dating an Existing Early Intervention Record

- 1 Select the desired record in the History grid.
The Program Information and Services Types grids will be populated.
- 2 Record the End Date in the **End Date** field in the History grid.
*The **Save** button enables.*
- 3 Click on the **Save** button to save your changes.



Where am I?

*Assigned Workload > FSS >
Tasks >Health Services tab>
Select a Child > Early
Intervention. tab.*



Step-by-Step: Invalidating an Existing Early Intervention Record

- 1 Select the desired record in the History grid.
The Program Information and Services Types grids will be populated.
- 2 Click on the **INV** checkbox for the record in the History grid.
*The **End Date** field will populate with the date if a date was not previously recorded.*
- 3 Click on the **Save** button to save your changes.



Where am I?

*Assigned Workload > FSS >
Tasks >Health Services tab>
Select a Child > Early
Intervention. tab.*

The Bio. Family Health Info. Tab

In accordance with New York State Law (SSL 373-a) and regulations (18 NYCRR 357.3), the health history of the child's biological parents must be provided to:

- foster parents;
- adoptive parents;
- the child if discharged to his or her own care; and
- an adopted former foster child upon the child's request.

The **Bio Family Health Info** tab is for recording specific information to the extent known about genetic or hereditary diseases or conditions in the child's biological family, and information concerning pre-natal care or medications the mother received while pregnant with the child. Recording pre-natal care information, to the extent available, is required for any preschool-aged foster child. Recording this information is optional for older children. Any information on the biological family's health history that could have an impact on the current or future health of the child is helpful for caseworkers and caregivers, and critical for the health practitioners treating the child. Therefore, OCFS requires that all fields on this tab be completed for foster children. The *Biological Family Health Information* window, which is accessed from the **Additional Information** button, can be used to record any additional information pertaining to the child's biological family.

The information contained in this window is tied to the relationships recorded in the *Family Relationship Matrix* (FRM) window in the FSS (e.g. mother, father and siblings). The biological parents of tracked children must be identified on the FRM for the Bio Family Health tab to be fully functional. Likewise siblings and half-siblings should be identified for more complete functionality. The following message will display when the FRM is incomplete:

"The Family Relationship Matrix has not been complete. Please complete the Family Relationship Matrix before returning to this tab."

CONNECTIONS will automatically check the checkboxes in the **Sibling in CONX Composite** column if certain health information has been recorded on the **Child Health Info.** and/or **Clinical Appointments** tabs for a child's sibling. When a medical condition is recorded for the mother or father, the system will automatically check the same medical condition checkbox for all biological children of that mother or father.

The Bio-Mother section displays questions pertaining to the birth of the selected child. Some sections on this tab require you to record more specific information relating to that condition in the "Specifics" column.

CONNECTIONS will automatically capture the name of the worker who updated the information, and the date it was updated. When the medical condition checkboxes are system populated, the **Updated By** column will be system-populated with the name of the worker who originally saved the health information.



All medical and mental health information about a child in foster care must be kept confidential in accordance with Social Services Law (section 372). Such information may be shared only with health practitioners, health staff, caseworkers, direct care workers, and foster and adoptive parents (with some exceptions) when they need it to provide adequate care and supervision. Refer to the Health Services Security topic for more details on health information confidentiality and security.



**Step-by-Step:
Accessing/Viewing the Bio. Family Health Info. Tab**

- 1 Select a child from the Child List grid.
*The **Child Health Info.** tab displays.*
- 2 Click on the **Bio Family Health Info** tab.
*The **Bio Family Health Info** window displays.*



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child*

Health Services - Hill,Jean - 5:23846537/C:21974770

File Options Reports Help
Case Name: Hill,Jean

Child List
 Active < 21 All Active All

Name	Sex	Person ID	Age	DOB	Responsible Agency	Medicaid Sta
Hill,Kelly	F	28924523	16	12/07/1990	Albany County Dss	
Hill,William	M	28924474	8	12/23/1997	Albany County Dss	

Child Health Info Clinical Appointment Early Intervention **Bio. Family Health Info.** HIV Risk Assessment Health Narrative

Health Information

Conditions	Mother Hill,Jean PID: 28924472	Father Hill,Calvin PID: 28924522	Biological Relatives Composite	Siblings Not In CONX Composite
Alcohol Abuse	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Biological Mother:

Did the mother receive pre-natal care? Yes No Unknown Specifics: _____

Did the mother take any medications during pregnancy? (If yes, specify) Yes No Unknown _____

Did the mother have any illnesses during pregnancy? (If yes, specify) Yes No Unknown _____

Did the mother use alcohol or drugs during pregnancy? (If yes, specify) Yes No Unknown alcohol

Has the child been regularly exposed to tobacco, including during pregnancy? Yes No Unknown Updated By: Wilson,Darryl Date Updated: 12/13/2006

Allergies **Additional Information** Save Cancel

Close

The Health Information section contains modifiable and view-only columns to view and record conditions for the family of the selected child. The condition of allergies can only be recorded on the *Allergies* window, which is accessed by clicking on the **Allergies** button. In order for the Mother, Father and Siblings in CONX columns to display there must be a relationship established in the Family Relationship Matrix from any stage. Upon accessing the tab, the grid may be system populated with information recorded from another tab or child. Since this information is modifiable at all times (except the Siblings in **CONX Composite** column) you may record multiple conditions for the family members prior to saving. The space to the right of the checkbox will be required when the conditions states to specify.

The **Health Information** section may contain the following columns:

Conditions	An alphabetical listing of genetic/hereditary conditions. Refer to Appendix C for a complete list of these conditions.
Mother/PID	Record the conditions for the mother listed in the stage. The mother's name and Person ID are displayed in the column header. This column is not visible if no one is identified as "Mother" in the Family Relationship Matrix.
Father/PID	Record the conditions for the father listed in the stage. The father's name and Person ID are displayed in the column header. This column is not visible if no one is identified as "Father" in the Family Relationship Matrix.
Biological Relatives Composite	Record conditions for biological relatives other than the biological parent, sibling or half-sibling.
Siblings Not in CONX Composite	Record conditions for the siblings and half-siblings not listed in Stage Composition or Historical Stage Composition.
Siblings In CONX Composite	A view-only column of conditions for siblings and half-siblings listed in Stage Composition or Historical Stage Composition. This column is not visible if no one is identified as "Sibling" in the Family Relationship Matrix.

The Biological Mother section consists of a list of questions, radio button answers, text fields and system populated **Updated By** and **Date Updated** fields. The questions in the Biological Mother section relate to her pregnancy for the selected child. Information must be recorded in this section in order to save if any changes on the window. An answer of Yes, No and Unknown may be recorded. In some instances, if you respond Yes to a question, you must specify in the corresponding **Specifics** field prior to saving; you can enter up to 250 characters in each field. A response of "Unknown" may be recorded when no information exists for the biological mother's pregnancy.

The **Updated By** and **Date Updated** fields will be system populate upon saving the Biological Mother questions.

The Biological Mother section is comprised of the following questions:

- *Did the mother receive pre-natal care?*
- *Did the mother take any medications during pregnancy? (If yes, specify)*
- *Did the mother have any illnesses during pregnancy? (If yes, specify)*
- *Did the mother use alcohol or drugs during pregnancy? (If yes, specify)*
- *Has the child been regularly exposed to tobacco, including during pregnancy?*

The window contains the following buttons:

Allergies	Clicking on this button displays the <i>Allergies</i> window where specific allergies are recorded.
------------------	---

Additional Information

Clicking on this button displays the *Biological Family Health Information* window which provides for recording additional health information about the family that is pertinent to the child. No information concerning HIV/AIDS on family members is to be recorded here.

This button is enabled when there are no unsaved changes on the **Bio Family Health Info.** tab.

Save

Clicking on this button saves work that has been recorded or modifications that have been made. The following message displays when any question in the Biological Mother section have not been completed:

“All questions related to biological mother’s pregnancy must be completed prior to save”

- Clicking on the **OK** button close the message and display the **Bio. Family Health Info** tab.

Cancel

The **Cancel** button is disabled until a modification is made on the open window. Clicking on this button cancels any changes made to information on the window since the last save. The following message displays upon clicking on the **Cancel** button,

“Do you want to cancel?”

Unsaved data and/or narrative(s) will be lost.”

- Clicking on the **Yes** button discards the unsaved changes and closes the window.
- Clicking on the **No** button closes the message without closing the window; all changes remain pending.

	Step-by-Step: Recording Information on the Bio. Family Health Info tab
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- 1** On the **Bio Family Health Info** tab, click on a checkbox in the appropriate column to select a condition(s) for a family member(s).
*The checkmark(s) populates.
The **Save** button enables.*
- 2** Record the information to the Biological Mother questions.
- 3** Click on the **Save** button.
*The following message displays when any question in the Biological Mother section have not been completed:
“All questions related to biological mother’s pregnancy must be completed prior to save”
Click on the **OK** button and return to **Step 2.***



Where am I?

Assigned Workload > FSS > Tasks > Health Services tab > Select a Child > Bio Family Health Info. tab



For more information on how to record Allergies and Additional Information refer to pages 66 and 68 for Step by Step instructions.

The Allergies Window

This window provides for viewing, recording and modifying allergy information for the child's biological family members. The *Allergies* window is accessed from the **Bio Family Health Info.** tab by clicking the **Allergies** button. This button enables once the **Bio Family Health Info.** tab has been saved or when allergy information has been previously entered and no changes have been made to the **Bio Family Health Info.** tab.

Allergy information can be recorded for the child's Mother, Father, Biological Relatives, and Siblings Not In CONX; the Siblings in CONX information is view-only. Once saved, a checkmark will be displayed for the family member in the Health Information grid on the **Bio. Family Health Info.** tab. When the Other checkbox on the Allergies window is selected, the accompanying Specify column becomes required. If you click the **OK** button prior to recording the specifics the following message displays:

"Must specify Allergy."

If you deselect the 'Other' checkbox for an allergen, any associated information that was previously recorded in the Specify column will be cleared.

When existing allergies are removed for a family member on the *Allergies* window, the Condition column on the **Bio. Family Health Info.** tab will be de-selected by the system for that person.



Step-by-Step: Accessing the Allergies Window

- 1 With a child selected in the Child List grid, click on the **Bio. Family Health Info.** tab.
- 2 Click on **Allergies** button.
The Allergies window displays.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > Bio. Family
Health Info. tab*

Health Services - Hill, Jean - 5:23846537/C:21974770

File Options Reports Help

Case Name: Hill, Jean

Allergies

File Help

Name	Relationship/PID
Hill, Jean	Mother/P:28924472
Hill, Kelly	
Hill, Calvin	Father/P:28924522
Biological Relatives	Composite
Siblings Not in CONX Composite	Composite
Siblings in CONX Composite	Composite

Child Health Info

Health Information

Conditions

Alcohol Abuse

Allergies

Biological Mother

Did the mother receive...
 Did the mother take...
 Did the mother have...
 Did the mother use...
 Has the child been...

Category	Allergen	Other
Environmental	<input type="checkbox"/> Ants	
	<input checked="" type="checkbox"/> Bees	
	<input type="checkbox"/> Cats	
	<input type="checkbox"/> Dogs	
	<input type="checkbox"/> Dust	
	<input type="checkbox"/> Dust Mites	
	<input type="checkbox"/> Mildew	
	<input type="checkbox"/> Mold	
	<input type="checkbox"/> Pollen	
	<input type="checkbox"/> Other (specify)	
Food	<input type="checkbox"/> Cashews	
	<input type="checkbox"/> Eggs	
	<input type="checkbox"/> Fish	
	<input type="checkbox"/> Milk Products	
	<input type="checkbox"/> Peanuts	

Health Narrative

Date Updated: 12/13/2006

OK Cancel

Close

The window provides a view of the family member selection grid, allergy selections and buttons. The **Name** field in the grid contains the Mother, Father, Biological Relatives, Siblings Not In CONX, and Siblings in CONX selections. The Relationships column identifies the family member's relationship to the child and Person ID. The Category, Allergen, and Other section provide for recording the allergy.



The window contains the following buttons:

- OK** Clicking on this button closes the *Allergies* window; any information entered in this window is saved to the database when you click on the **Save** button on the **Bio. Family Health Info.** tab.
- Cancel** If changes have not been saved when you click on the **Cancel** button, the following message displays:
"Changes have not been saved. Do you want to Cancel?"
- Click on the **Yes** button to close the window without saving the information.
 - Click on the **No** button to leave the window open; all changes remain pending



Step-by-Step: Recording Allergies

- 1 On the *Allergies* window, select the name of the family member or composite for which you want to record allergies.
The Allergen section enables.
- 2 In the appropriate category, click on a checkbox to select an allergen(s) for a family member(s).
*The checkmark(s) populates. If "Other" is selected, the accompanying Other column is required. The **OK** button enables.*
- 3 If "Other" was selected record the appropriate Allergen.
- 4 Click on the **OK** button.
*The **Bio. Family Health Info.** tab displays. When "Other" is selected and an allergy is not specified, the following message displays:
"Must specify allergy"
Click on the **OK** button and return to **Step 3.***



Where am I?

Assigned Workload > FSS > Tasks > Health Services tab > Select a Child > Bio. Family Health Info. tab > Allergies button

The Biological Family Health Information Window

This *Biological Family Health Information* window provides for recording additional health information about the family that is pertinent to the child. No information concerning HIV/AIDS on family members is to be recorded here. It is accessed by clicking on the **Additional Information** button located on the **Bio. Family Health Info.** tab. The window is comprised of a header, footer, various field and buttons.



Step-by-Step: Accessing the Biological Family Health Information Window

- 1 With a child selected in the Child List grid, click on the **Bio. Family Health Info.** tab.
- 2 Click on the **Additional Information** button.
The Biological Family Health Information window displays.



Where am I?

Assigned Workload > FSS > Tasks > Health Services tab > Select a Child > Bio. Family Health Info. tab

Biological Family Health Information - Snow, Karen - P:26320159

File Options Help

WARNING: Do not enter information on the HIV or AIDS history or status of a biological family member (parent, sibling or relative).

Provide any additional information regarding any health conditions:

Mother: Josey, Jenna PID: 23321

Father: Crandel, Joseph PID: 22132

Child's Biological Siblings

Child's Biological Relatives

Updated By: Banegas, Deidy B Date Updated: 7/15/2003

Mother's General Information	Father's General Information	Deceased Parent
Mother's Name: Snow, Karen	Father's Name: Snow, Peter	Is Mother deceased? No
Mother's DOB: 12/15/1982	Father's DOB: 1/30/1980	Age at Mother's death?
Mother's Age at time of child's birth: 17		Specifics of Mother's cause of death:
Mother's Race/Ethnicity: White/ Non-Hispanic	Father's Race/Ethnicity: White/ Non-Hispanic	Is Father deceased? No
		Age at Father's death?
		Specifics of Father's cause of Death:

Spell Check Save Cancel Close

The Title Bar contains the Child Name and Person ID as well as the **File, Options, and Help** menus. The following warning statement displays at all times:

“WARNING: Do not enter information on the HIV or AIDS history or status of a biological family member (parent, sibling or relative).”

In the **Provide any additional information regarding any health conditions** section, there are text fields holding a maximum of 1000 characters, where you may record narrative health information pertaining to the child’s biological mother, biological father, biological siblings and biological relatives. The field title indicates the relationship (e.g., mother). The fields for the biological mother and father include the relationship, name and Person ID. Since these relationships are derived from the Family Relationship Matrix, the field disables if no active mother or father relationship is established. Once information is recorded the Update By and Date Update fields will be populated.

Located at the bottom of the window is view-only general information about the biological mother and father (i.e. name, DOB, race, ethnicity). The displayed information will be pulled from the **Stage Composition** tab (current or historical). If either the mother or father is deceased “Yes” will display for the question (e.g. **Is Mother deceased?**) and the **Specifics** field enables; the cause of death can be recorded in this field.

The General Information section contains the following:

Mother's General Information	Father's General Information	Deceased Parent
Mother's Name Mother's DOB Mother Age at time of the child's birth. Mother's Race/Ethnicity	Father's Name Father's DOB Father's Race/Ethnicity	Is Mother deceased? Age at Mother's death? Specifics of Mother's cause of death: Is Father deceased? Age at Father's death? Specifics of Father's cause of death:

The window contains the following buttons:

- Spell Check** This button allows you to check the narrative for spelling errors.
- Save** Clicking on this button saves work that has been recorded or modifications that have been made.
- Cancel** Clicking on this button cancels any changes made to the information on the window since the last save. The **Cancel** button is disabled until you make a modification. When you click on the **Cancel** button, the following message displays:
- “Do you want to cancel?
Unsaved data and/or narrative(s) will be lost.”*
- Clicking on the **Yes** button cancels the changes and all information reverts to its state after the last save.
 - Clicking on the **No** button ends the cancellation request and returns to the window for additional modifications (or to enable the **Save** button).
- Close** Clicking on this button closes the window and displays the **Bio Family Health Info** tab. If any unsaved changes exist on the window when you click on this button, the following message displays:
- “Do you want to Exit?
Unsaved data and/or narrative(s) will be lost.”*
- Clicking on the **Yes** button discards the unsaved changes and closes the window.
 - Clicking on the **No** button closes the message without closing the window; all changes remain pending.



Step-by-Step: Recording Additional Information on Biological Family Health Information Window

- 1 From the **Bio. Family Health Info.** tab, click on the **Additional Information** button.
The Biological Family Health Information window displays.
- 2 Click in the appropriate narrative field and record relevant narrative.
*If desired, click on the **Spell Check** button to initiate the spell check process. The **Save** button enables.*
- 3 If applicable, record biological parent's cause of death.
- 4 Click on the **Save** button.
*The **Updated By** and **Date Updated** fields populate.*



Where am I?

Assigned Workload > FSS > Tasks > Health Services tab > Select a Child > Bio. Family Health Info. tab



Do not record HIV or AIDS as the cause of death. Record the exact illness if known or a general term such as Infectious Disease, if unknown.

The Last Update Information Window

The *Last Update Information* window provides for viewing the date and worker that last made changes to health information. This window will be accessed from the **Options** menu on the **Bio Family Health** tab or *Biological Family Health Information* window (the window that appears when the **Additional Information** button is clicked). When accessed from the **Options** menu on the **Bio. Family Health Info.** tab, the *Last Update Information* window displays any updated health information from the Bio Family Health tab. Conversely, when accessing the *Last Update Information* window from the *Biological Family Health Information* window only updated health information from this window displays.

	<p>Step-by-Step: Accessing the <i>Last Update Information</i> Window from the Bio. Family Health Info. Tab OR Accessing the <i>Last Update Information</i> Window from the Biological Family Health Information Window</p>
---	---

- 1 On the **Bio. Family Health Info.** tab, click on the **Options** menu and select **Last Update Information** command.

The Last Update Information window displays.

OR

- 2 On the *Biological Family Health Information* window, click on the **Options** menu and select the **Last Update Information** command.

The Last Update window displays.

- 3 Click on the **Close** button.
The Last Update window closes and the Biological Family Health Information window displays.

OR

- 4 Click on the **Close** button.
*The Biological Health Information window closes and the **Bio. Family Health Info.** tab displays.*



Where am I?

Assigned Workload > FSS > Tasks > Health Services tab > Select a Child > Bio. Family Health Info. tab



Where am I?

Assigned Workload > FSS > Tasks > Health Services tab > Select a Child > Bio. Family Health Info. tab > Additional Information button

**View of the Last Update Information Window
 Accessed by clicking on the Options menu from the Bio. Family Health Info. Tab**

Health Services - Stage Name - S: 22633643/C: 21351774

File Options Reports Help

Case Name: Snow, Karen

Child List

Active < 21 All Active All

Name	Sex	Person ID	Age	DOB	Resp. Agency	FC	Medicaid Status	EI
▶ Simpson, Bart	M	54973	11	10/05/1993	Albany County DSS	<input checked="" type="checkbox"/>	Eligible - Roster	<input type="checkbox"/>
▶ Simpson, Lisa	F	54985	3	06/14/2001	Sarah Minnie Badger	<input type="checkbox"/>	Ineligible	<input type="checkbox"/>

Child Health Info.

Health Information

Conditions

- ▶ Alcoholism
- Allergies (specify)

Biological Mother:

Did the mother receive
 Did the mother take ar
 Did the mother have a
 Did the mother use alc

Has the child been regularly exposed to tobacco, including during pregnancy? Yes No Unknown [Bangeas, Deidy E] [12/13/2004]

Last Update Information - Snow, Karen - P: 26320159

File Help

Last Update Information

Relative	Name	Person ID	Case ID	Stage ID	Updated By	Date
▶ Mother	Josey, Jenna	23321	1223211	22633643	Bangeas, Deidy E	12/14/2004
Father	Crandel, Joseph	22132	12055555	22633643	Nice, Sharon	12/30/2004
Biological Relatives Composit			21351774	22633643	Smith, Travis	12/30/2004
Siblings Not In CONX Compo:			21351774	22633643	Smith, Travis	12/30/2004
Siblings In CONX Composite			21145555	22633643	Ferndal, Bill	12/30/2004

Close

Save Cancel

Close

HIV Risk Assessment

The **HIV Risk Assessment** tab provides for recording the HIV risk assessment which is required for all children placed in foster care. Additionally, workers will record information pertaining to the child's capacity to consent to HIV testing, the presence of risk factors, and test results. A risk assessment is not required for children receiving preventive or protective services only. Workers are **not** to record any HIV information for children receiving preventive or protective services in CONNECTIONS since the criteria for disclosure of confidential HIV-related information is specific to children in foster care.



All medical and mental health information about a child in foster care must be kept confidential in accordance with Social Services Law (section 372). Such information may be shared only with health practitioners, health staff, caseworkers, direct care workers, and foster and adoptive parents (with some exceptions) when they need it to provide adequate care and supervision. Refer to the Health Services Security topic for more details on health information confidentiality and security.



Step-by-Step: Accessing the HIV Risk Assessment Tab

- 1 Select a child from the Child List grid.
*The **Child Health Info.** tab displays.*
- 2 Click on the **HIV Risk Assessment** tab.
*The **HIV Risk Assessment** tab displays.*



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child*

Health Services - Hill, Jean - 5:23846537/C:21974770

File Options Reports Help
Case Name: Hill, Jean

Child List
 Active < 21 All Active All

Name	Sex	Person ID	Age	DOB	Responsible Agency	Medicaid Sta
Hill, Kelly	F	28924523	16	12/07/1990	Albany County Dss	
Hill, William	M	28924474	8	12/23/1997	Albany County Dss	

Child Health Info Clinical Appointment Early Intervention Bio. Family Health Info **HIV Risk Assessment** Health Narrative

HIV Risk Assessment History

Date of HIV Risk Assessment	Newborn Screening	Assessment Complete	Risk Factors Exist	Child Has Capacity	Test Performed	Test Date	Test Results	Updated By	INV
[Empty Grid]									

HIV Risk Assessment

Date of HIV Risk Assessment: 09/05/2006 Will child consent to HIV test? Yes No

Is this a newborn screening? Yes No Child consents to: Anonymous Confidential

Does child have capacity to consent to HIV test? Yes No

Does child have HIV Risk Factors? Yes No

HIV Test

Date of HIV Test: 10/05/2006 Result of HIV Test: Positive Negative

Clear Save Cancel

Close

HIV Risk Assessment Tab

The **HIV Risk Assessment** tab consists of a history grid, HIV Risk Assessment and Test sections and various buttons. The HIV Risk Assessment History grid contains a summary of previously saved HIV Risk Assessments. Once a history record is selected, the HIV Risk Assessment section is populated with the record's information. Records are listed in descending order by date, from most current to oldest; however, the sort order can be changed by clicking on a column heading (e.g., **Test Date**, **INV**). The grid contains the following columns:

- Date of HIV Risk Assessment** A non-modifiable date field indicating the date on which the risk assessment was completed.
- Newborn Screening** A non-modifiable checkmark in this field indicates that the HIV test results were completed using information from a Newborn Screening.
- Assessment Complete** A non-modifiable checkmark in this field indicates an assessment has been completed and saved.



All medical and mental health information about a child in foster care must be kept confidential in accordance with Social Services Law (section 372). Such information may be shared only with health practitioners, health staff, caseworkers, direct care workers, and foster and adoptive parents (with some exceptions) when they need it to provide adequate care and supervision. Refer to the Health Services Security topic for more details on health information confidentiality and security.

Risk Factors Exist	A non-modifiable checkmark in this field indicates that one or more risk factors have been identified for a child.
Child Has Capacity	A non-modifiable checkmark in this field indicates the child has been determined to have the capacity to consent to HIV testing.
Test Performed	A non-modifiable checkmark in this field indicates an HIV test was performed.
Test Date	The Test Date column is a non-modifiable date field indicating the date on which the HIV test was performed.
Test Results	This non-modifiable field is populated with results (Positive or Negative) of the HIV test.
Updated By	This non-modifiable field is populated with name of the worker who last saved information.
INV	A checkmark in this modifiable field indicates the selected record was incorrectly recorded in CONNECTIONS. “Invalid” in CONNECTIONS means that the information was <i>never</i> correct—that it was recorded in error. Invalid entries will display at the bottom of the list and will not be included in any outputs.

In the HIV Risk Assessment section you will record information about the assessment. The section contains a date field and series of questions concerning:

- the child’s capacity to consent to HIV-related services;
- the presence or absence of HIV risk factors; and
- who has consented to HIV-related services—whether the child or someone with the authority to consent.

The capacity to consent to HIV testing and treatment must be assessed for all children placed in foster care. Capacity to consent means:

An individual’s ability, determined without regard to the individual’s age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure; or of a proposed disclosure of confidential HIV-related information, as the case may be, and to make an informed decision about the service, treatment, procedure, or disclosure.

The capacity to consent should be determined by a qualified health professional or a district/agency staff person who has received training specifically on HIV assessments and procedures. Any additional information on the HIV Risk Assessment **must** be recorded in the **Health Narrative** tab, rather than in **Progress Notes**.

Consent for HIV testing may be obtained from the child with capacity to consent or from the person legally authorized to consent on behalf of the child (e.g. parent) if the child lacks the capacity to consent. If the parent is “unavailable” or refuses to grant consent, the commissioner can sign the consent if the child was adjudicated as an abused or neglected child or removed from the home on an emergency basis pursuant to Article 10. The commissioner can sign the consent if the commissioner has assumed guardianship and custody of the child through surrender or the termination of parental rights with respect to the child in question. Otherwise, a court order is required unless the necessary consent is obtained. When a child has the capacity to consent and refuses to take an HIV test, no one can force that child to take the test.

The **Date of HIV Risk Assessment** field is used to indicate the date on which the risk assessment was completed. The actual HIV test may be performed at a later date. This field is the only modifiable field upon entering the **HIV Risk Assessment** tab when no history record is selected. Once a date is selected the following question will display,

Is this a newborn screening?

The "**Is this a newborn screening?**" question is used to indicate if the test results were from the child's Newborn Screening. This question displays when a date is selected in the **Date of HIV Risk Assessment** field. An affirmative response to the above question will enable the HIV Test section which provides for recording the Newborn Screening date and HIV test result information. The HIV Risk Assessment is completed after this information is recorded and saved. When the **No** response is selected, the following two questions display:

- *Does child have capacity to consent to HIV test?* (Yes or No response)
- *Does child have HIV risk factors?* (Yes or No response)

When and how additional information displays depends upon your combination of responses to the above questions. When all required responses are completed the **Save** button will enable. The HIV Risk Assessment section contains the following additional questions:

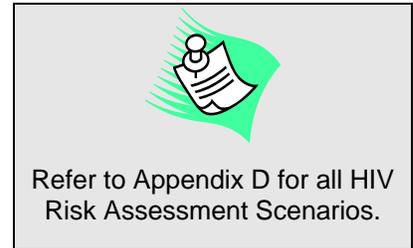
- *Will child consent to test?* (Yes or No response)
- *Child consents to:* (Anonymous or Confidential response)
- *Legal consent obtained from:* (Parent/Legal Guardian or LDSS Commissioner or Court response)

The completion of this assessment is based on the information currently available to you. The information is drawn from both written records and discussions with the parents and the child. State regulation 18 NYCRR 441.22 further defines the risk factors to consider when documenting an HIV Risk Assessment.

All risk factor information **must** be documented in the **Health Narrative** tab. The presence of one risk factor is enough for a positive risk assessment therefore requiring an HIV test if consent can be obtained. If there are no risk factors present, then an HIV test is not required, although a child with the capacity to consent may still decide to take a test. Designated agency staff must provide any child taking an HIV test with pre-and post-test counseling.

The HIV Test section contains a **Date of HIV Test** field and **Result of HIV Test** radio buttons. The **Date of HIV Test** field provides for documenting the date of the HIV test, which can be backdated to the child's date of birth. The **Result of HIV Test** contains the Positive and Negative radio buttons to record the results of the HIV test.

If the child with capacity to consent has chosen to take an anonymous HIV test, do not record the date or results of the test on the **HIV Risk Assessment** tab, even if the child provides the information to you. Encourage the child to agree to a confidential test so that test results can be confirmed and recorded on the tab.



The **HIV Risk Assessment** tab contains the following buttons:

- Clear** This button clears information in the HIV Risk Assessment section allowing you to enter new information.
- Save** The **Save** button enables when all required components are complete. Clicking on this button saves the record.
- Cancel** The **Cancel** button is disabled until a modification is made on the open window. Clicking on this button cancels any changes made to information on the window since the last save. The following message displays upon clicking on the **Cancel** button,
- “Do you want to cancel?
Unsaved data and/or narrative(s) will be lost.”*
- Clicking on the **Yes** button discards the unsaved changes.
 - Clicking on the **No** button leaves the window open; all changes remain pending.

 **Step-by-Step:
Recording an HIV Risk Assessment**

- 1 On the **HIV Risk Assessment** tab, record the date of the risk assessment.
The following question displays: Is this a newborn screening?
- 2 Click on the **Yes** radio button in response to the question.
*The **Save** button enables. Proceed to Step 4.*

OR

*Click on the **No** radio button.
The following questions display: Does child have capacity to consent to HIV test? & Does child have HIV Risk Factors?*
- 3 Since specific questions display based on prior responses, record applicable responses for any question displaying in the HIV Risk Assessment section.
*If the **Save** button enables, proceed to Step 5.*
- 4 If enabled, record the **Date of HIV Test** and **Result of HIV Test** in the HIV Test section.
- 5 Click on the **Save** button.
*The **HIV Risk Assessment** tab displays.*



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child > HIV Risk
Assessment tab*



Refer to Appendix D for all HIV question scenarios.

When a worker selects a record from the HIV Risk Assessment History grid for which all required responses were recorded but the HIV Test section was not completed, additional information can be added to the HIV Test section.



Step-by-Step: Adding Additional Information to an HIV Risk Assessment

- 1 On the **HIV Risk Assessment** tab, select a record from the HIV Risk assessment History grid.
The HIV Test section enables.
- 2 Record the **Date of HIV Test** and **Result of HIV Test** in the HIV Test section.
*The **Save** button enables.*
- 3 Click on the **Save** button.
*The **HIV Risk Assessment** tab displays.*



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab>
Select a Child > HIV Risk
Assessment tab*



A record may only be modified if the HIV Test section is enabled for the selected record.

Invalidating Information on the HIV Risk Assessment Tab

With the exception of the **INV** field all fields in the HIV Risk Assessment History grid are non-modifiable. A record may be marked invalid if it was recorded in error and the information was never correct. After invalidating a record a checkmark displays and the **Save** button enables.



Step-by-Step: Invalidating Information on the HIV Risk Assessment Tab

- 1 With a record selected in the HIV Risk Assessment History grid, click on the **INV** checkbox to invalidate the record.
*The **INV** field populates with a checkmark. The **Save** button enables.*
- 2 Click on the **Save** button.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab>
Select a Child > HIV Risk
Assessment tab*

Health Narrative

Health Narrative versus Progress Notes

Health-related information that pertains to the INV stage should be recorded in progress notes in the CPS INV stage. For example, information regarding injuries a child sustained as a result of abuse would be documented in the INV stage.

The **Health Narrative** tab should be used to record specific clinical information that may have no other place in the Health Services component, or for recording information that should not be a part of the Health History or Summary. This last use would occur, for example, when a minor child with the capacity to consent receives reproductive health or substance abuse services and does not want this information disclosed to anyone else.

The difference between Progress Notes and the Health Narrative is that the Health Narrative is subject to enhanced security. Progress Notes can be viewed by all workers who have a role in the stage, including caseworkers assigned such role from any agency, who are not case managers, case planners or CPS Worker/Monitors, and by workers who have an implied role in the case. Workers in a different county, for example, who have an open stage with an individual in common with your stage can access the Progress Notes you record.

The **Health Narrative** tab may be used for recording information that is not appropriate for recording in Progress Notes and for documenting confidential, child-specific health services and activities, including:

- Any information related to HIV/AIDS services.
- Notes on substance abuse diagnoses and services.
- Notes on mental health evaluations.
- Notes on family planning and reproductive health.

The Health-related information that should be recorded in progress notes (FSS) includes:

- Information about consents and efforts to obtain them.
- Appointment information.
- Any assistance needed for the appointments. (e.g. transportation)
- Information regarding health services that pertains to service delivery (e.g. mental health issues that might make it difficult for the various goals to be met).



All medical and mental health information about a child in foster care must be kept confidential in accordance with Social Services Law (section 372). Such information may be shared only with health practitioners, health staff, caseworkers, direct care workers, and foster and adoptive parents (with some exceptions) when they need it to provide adequate care and supervision. Refer to the Health Services Security topic for more details on health information confidentiality and security.



Refer to the Security of Health Information section for a detail discussion of security role and responsibilities.



Public Health Law (Article 27-F) defines confidential HIV-related information as “any information concerning whether an individual has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify an individual as having one or more such conditions, including information pertaining to such individual’s contacts.”



Step-by-Step: Accessing the Health Narrative Tab

- 1 Select a child from the Child List grid.
The **Child Health Info.** tab displays.
- 2 Click on the **Health Narrative** tab.
*The **Health Narrative** tab displays.*



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Select a Child*

Health Narrative Tab

The **Health Narrative** tab becomes enabled when you select a child in the Select Child List grid. Health Narratives can be added to both open and closed stages. The narrative entries for a selected child appear in the Narrative Entry grid. The Narrative Entry grid includes the following columns: Entry Date, Entry Time and Author. The grid is sorted in descending order by Entry Date and Entry Time so the latest entry for a child appears at the top. The narrative field provides for recording your entries. Once a narrative is recorded and saved, it can no longer be modified.

The following buttons appear on the bottom of the **Health Narrative** tab:

- | | |
|----------------|---|
| Clear | This button enables when you select an entry in the narrative entry grid. Clicking on the Clear button clears out the text in the narrative field and deselects the entry previously selected in the narrative entry grid. |
| Summary | This button enables when the selected child has multiple health narrative entries appearing in the narrative entry grid. Clicking on the Summary button opens the <i>Health Narrative Summary</i> window. |
| Save | This button becomes enabled once you enter text into the narrative field. Clicking on the Save button stores the new narrative entry to the database and adds a row to the narrative entry grid. Once a narrative is recorded and saved, it can no longer be modified. |
| Cancel | This button only enables when you have unsaved changes on the window. Clicking on the Cancel button displays the following message:

<p style="text-align: center;"><i>“Changes have not been saved. Do you want to Cancel?”</i></p> <ul style="list-style-type: none"> • Click on the Yes button to close the window without saving the information. • Click on the No button to leave the window open; all changes remain pending. |



All medical and mental health information about a child in foster care must be kept confidential in accordance with Social Services Law (section 372). Such information may be shared only with health practitioners, health staff, caseworkers, direct care workers, and foster and adoptive parents (with some exceptions) when they need it to provide adequate care and supervision. Refer to the Health Services Security topic for more details on health information confidentiality and security.

Recording a Health Narrative

Health narratives can be added to both open and closed stages based upon your security. You may edit the text before saving by utilizing the text control toolbar. Additionally, the text control toolbar will provide for printing a saved or unsaved entry. The entry is frozen once it is saved to the database and cannot be modified.



Step-by-Step: Recording a Health Narrative

- 1 With the child selected, click on the **Health Narrative** tab.
*The **Health Narrative** tab enables.*
- 2 Record your **narrative** in the narrative text field.
*The **Save** button enables.*
- 3 Click on the **Save** button to save your changes.



Where am I?

*Assigned Workload > FSS >
Tasks button > Health Services
tab > Select a Child*

Health Services - Hill,Jean - 5:23846537/C:21974770

File Options Reports Help
Case Name: Hill,Jean

Child List

Active < 21 All Active All

	Name	Sex	Person ID	Age	DOB	Responsible Agency	Medicaid Sta
▶	Hill,Kelly	F	28924523	16	12/07/1990	Albany County Dss	
	Hill,William	M	28924474	8	12/23/1997	Albany County Dss	

Child Health Info Clinical Appointment Early Intervention Bio. Family Health Info. HIV Risk Assessment **Health Narrative**

Entry Date	Entry Time	Author
▶ 12/13/2006	11:33:57 AM	Wilson,Darryl
12/13/2006	11:32:38 AM	Wilson,Darryl

Arranged for appointment with ob/gyn at Albany Medical. Appointment for 11/10/2006.

Viewing a Health Narrative Entry

You can view a child's Health Narrative by selecting a child in the Child List grid from the Health Services window and selecting the Health Narrative tab. The Narrative entry grid is sorted in descending order by Entry Date and Entry time so that the latest entry for a child appears at the top. When you select an entry in the narrative entry grid, the text of the entry appears in the narrative field and is view only. When you are unassigned from a stage, you will only be able to view entries created prior to your un-assignment.



Step-by-Step: Viewing a Health Narrative Entry

- 1 Click on the **Health Narrative** tab with the child selected.
*The **Health Narrative** tab displays.*
- 2 Select the desired entry in the narrative entry grid.
*The text of the entry displays in the narrative field and is view only. The **Clear** button enables. If the child you selected has multiple health narrative entries the **Summary** button will enable.*
- 3 Click on the **Clear** button.
The text in the narrative field will clear and the entry will be deselected.



Where am I?

Assigned Workload > FSS >
Tasks >Health Services tab>
Select a Child

Overview of the Health Narrative Summary Window

When the selected child has multiple health narrative entries appearing in the narrative entry grid the **Summary** button will be enabled and you will be able to view all of the narrative entries in the *Health Narrative Summary* window. The Health Narrative Summary text field displays the text of all the entries appearing in the narrative entry grid in the same order as they appear in the narrative entry grid. The *Health Narrative Summary* window contains the **File** and **Help** menus.



The **Summary** button will be disabled if there is only one narrative entry for the selected child.

To view all of the narratives, click on the **Summary** button. All the entries in the Health Narrative will appear, date-stamped and in descending chronological order. The name of the worker who made the entry, and its date and time, will display above each entry.

The Health Narrative Summary text field is view only and the text control tool which provides for editing and printing is unavailable. The **Print Screen** key must be used to generate a printed copy of the information on the *Health Narrative Summary* window.



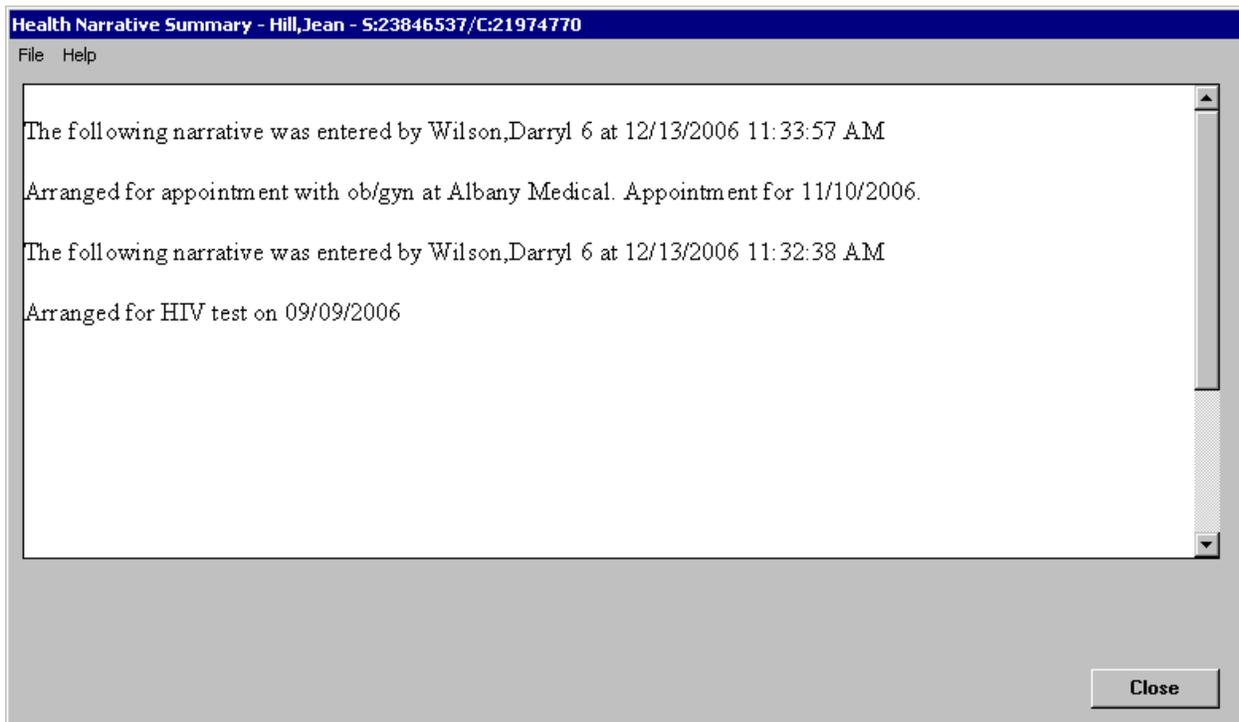
Step-by-Step: Viewing the Health Narrative Summary

- 1 Select a child in the Child List grid.
*The Health Narrative will be enabled. The **Summary** button enables.*
- 2 Click on the **Summary** button.
*The Health Narrative Summary window displays. The **Close** button is enabled.*
- 3 Click on the **Close** button.
*The **Health Narrative** tab displays.*



Where am I?

*Assigned Workload > FSS >
Tasks >Health Services tab>
Select a Child > Health
Narrative tab.*



Child Health History and Health Summary Reports

Introduction

According to Social Services Law and Department regulations, the comprehensive health history of a child in foster care must be provided, to the extent known and available, including HIV-related information, to the following persons:

- The receiving agency when the care of the child is transferred from one authorized agency to another for placement;
- Foster parents at the time the child is placed or as soon as possible;
- Adoptive parents and prospective adoptive parents;
- Parents or guardians at the time of discharge of the child from foster care, including all medical treatment during the time in foster care; except that confidential HIV-related information must not be disclosed without a written release from the child if the child has the capacity to consent;
- The child himself or herself at the time of discharge to independent living; and
- The child's physician or medical provider in order to facilitate care and treatment for the child.

Disclosure of HIV Information

Since the information concerning HIV/AIDS is of a sensitive nature, the law pertaining to confidentiality, disclosure and re-disclosure has strict provisions. For a child with the capacity to consent, HIV-related services must be disclosed to foster parents, adoptive parents, and prospective adoptive parents with or without the child's consent, but this disclosure does not extend to the child's birth parents unless the child gives written consent. It is critical to preserve all HIV-related information (including the HIV test) in a confidential manner.

In all cases when HIV-related information is disclosed, a warning statement against further disclosure or re-disclosure must be given to those receiving the information. The warning statement reads as follows:

"This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure."



Public Health Law (Article 27-F) defines confidential HIV-related information as "any information concerning whether an individual has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify an individual as having one or more such conditions, including information pertaining to such individual's contacts."

Services to which Minors Can Consent

Under certain circumstances and conditions, there are some specific services for which a minor can consent.

A foster child who has consented to treatment for substance abuse or sexually transmitted diseases, or has consented to mental health or family planning and reproduction services (including pregnancy termination), has the right to confidentiality. Information about the services received may not be shared with caseworkers, health staff, the child's foster parent, or the birth parent or guardian without the express consent of the child. These services should not be recorded on the child's **Clinical Appointments** or **Child Health Info.** tabs unless the child has consented to the disclosure of this information.



Prior to producing a Health History for parents upon discharge of a child from foster care, if the child has capacity to consent and did not consent to disclosing the HIV information, you **must** remember to omit the HIV section. HIV information is not routinely included in court summaries. The judge must order it specifically.



For information on the disclosure and re-disclosure of HIV information refer to the Health Services Manual at www.ocfs.state.ny.us/main/sppd/health_services/manual.asp.



When a Health History is generated upon transfer or discharge of a foster child, CONNECTIONS might print out this information, with the exception of the substance abuse domain, you must remember to omit disclosed information on services for which the child has provided consent since there is no way to separate information except by recording it in the Health Narrative tab.

Health History and Health Summary Report

CONNECTIONS provides for generating a summary of health information with the Child Health History Report and Child Health Summary Report. The Health Summary provides only current, valid information recorded in Health Services that has not been end-dated. The Health History is comprehensive and includes all current information that has been end-dated. It excludes only information that has been invalidated and information recorded in the **Health Narrative** tab.

Another difference between the Health Summary and the Health History report is that the Health History report provides for selecting specific categories of information to exclude from the report. For example, a child who has received substance abuse services is being discharged from foster care to his or her parents. The child had the capacity to consent to those services, and does not wish to disclose this information to the parents. In this case, when you provide the parents the mandated health history upon the child's discharge, you would choose the Health History Report and exclude information about substance abuse services.

For both reports, the names of the biological parents have been removed from the biological family health section. This has been done to prevent this information from being shared with those permitted or required to have the child's health information, but not the identity of the child's biological parents. Note that these names have been removed from the report outputs only and not from the actual windows in CONNECTIONS.

Child Health History Report

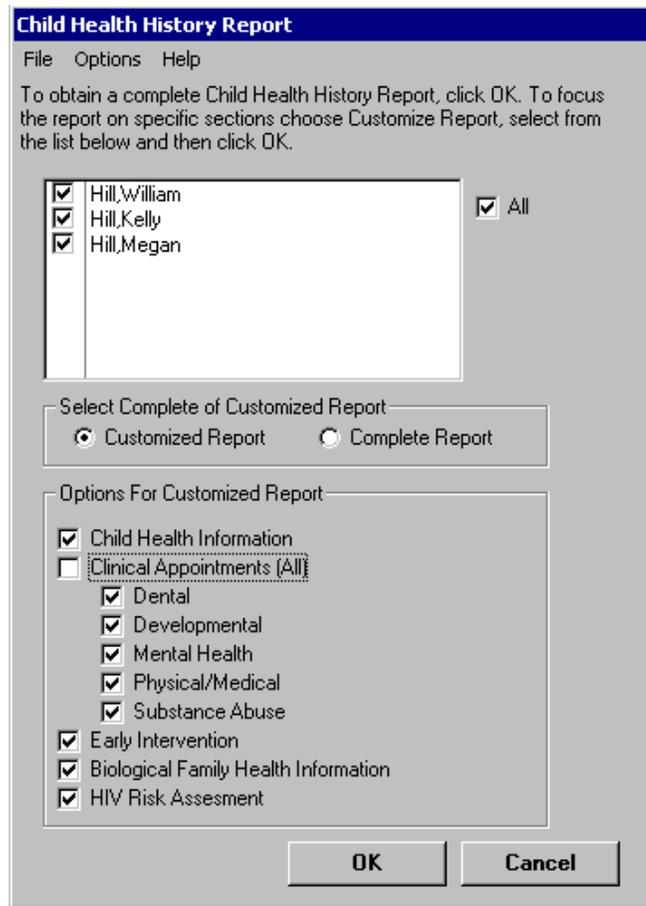
The Health Services component provides a summary of critical information. The Child Health History report compiles the information recorded on the Clinical Appointments, HIV Risk Assessments, Early Intervention services, Biological Family Health as well as Child Health information such as medications, allergies, hospitalizations and durable medical equipment.

The process to initiate generating a report for the child(ren) begins upon selecting the **Child Health History** command on the **Reports** menu. This *Child Health History Report* window provides options to generate a comprehensive report with information from all tabs related to the child(ren) or a customized report with only the selected information on one or multiple tabs. Once generated, the report includes all historical (active and end-dated) health information for the child(ren) in the list. The information will be sorted in descending order by Start Date displaying the most recent first.



Step-by-Step: Accessing the Child Health History Report

- 1** Click on the **WORK** button on the CONNECTIONS Toolbar.
The Assigned Workload displays.
- 2** Select the appropriate FSS stage and click on the **Tasks...** button.
The Family Services Stage window displays.
- 3** Click on the **Health Services** tab.
The Health Services window displays.
- 4** With a child selected in the Child List grid, click on the **Reports** menu and select the **Child Health History Report** command.
The Child Health History Report window displays.



Child Health History Report Window

The window contains various sections including a child list, commands for generating a complete or customized report and buttons. The child list is comprised of children from the stage. The children that display in the child list will depend on the worker's role in the stage, the assigned Business Function(s) and responsibility to child. You can select one or more children or use the 'Select All' command to automatically select all children to generate a report.

Upon entering the window, the **Complete Report** radio button is selected. When this button is selected, the information from all Health Services tabs is included in the report, with the exception of the **Health Narrative** tab. Selecting the **Customized Report** button enables the Options For Customized Report section. In this section you can select specific tabs and within the **Clinical Appointment** tab, you can select specific Domain Types to print. This section contains the following selections:

- Child Health Information.
- Clinical Appointment (All) The following sub-options include:
 - Dental
 - Developmental
 - Mental Health
 - Physical/Medical
 - Substance Abuse
- Early Intervention
- Biological Family Health Information
- HIV Risk Assessment

The window contains the following buttons:

- OK** This button generates the Child Health History Report.
- Cancel** This button closes the window and displays the *Heath Services* window.

 **Step-by-Step:
Generating the Child Health History Report**

- 1 On the Child Health History Report window, deselect the All checkbox to select a specific child(ren) from the child list.
- 2 Select the type of report to be generated.
*If the Complete Report is desired Proceed to **Step 4**.*
- 3 Select the appropriate commands for the customized report.
The checkmark(s) display(s).
- 4 Click on the **OK** button.
The Child Health History Report displays.
- 5 Click on the Print button.
- 6 Click on the **Close** button.
The Child Health History Report window displays.
- 7 Click on the **Cancel** button.
The Health Services window displays.



Where am I?

*Assigned Workload > FSS >
Tasks > Health Services tab >
Reports menu > Child Health
History command*

The report is divided into the following sections:

- Header and Footer
- Child Detail
- Health Summary Detail



See Appendix E for a sample of the Child Health History Report.

Displayed on all pages of the report, the header contains following system information populated information:

- Report title
- Sensitive Case indicator
- Confidential labels
- Case Name
- Case ID
- Case Initiation Date
- Stage Name
- Stage ID
- Report Date
- District of the Case Manager
- District/Agency of the Case Planner

Child Detail Section

Once generated, the Child Health History Detail section of the report displays information for the requested selections in the Health Services component. The report will contain all active and end-dated entries, omitting any invalidated information. When no information has been recorded for a section “*No Data Available*” will display. The Early Intervention section will display information for children under the age of four. At the end of the Child Detail section the following statement displays:

“This report represents the child’s current health status. Additional information may be available.”

The footer will contain standard information about the report, including:

- Date Printed
- OCFS Form label
- Page number and total pages

Child Health Summary

The Child Health Summary report displays active and current information in the Health Services component. The *Child Health Summary Report* window is accessed from the **Child Health Summary** command on the **Reports** menu. The report is generated after a child or all children are selected. The children available for selection on this window will depend on the worker’s Business Functions, role and the agency’s designated responsibility for the child. Moreover, the security profile of the worker will determine the information pulled from the tabs and displayed in the report tabs.



Step-by-Step: Accessing the Child Health Summary Report

- 1 Click on the **WORK** button on the CONNECTIONS Toolbar.
The Assigned Workload displays.
- 2 Select the appropriate FSS stage and click on the **Tasks...** button.
The Family Services Stage window displays.
- 3 Click on the **Health Services** tab.
The Health Services window displays.
- 4 With a child selected in the Child List grid, click on the **Reports** menu and select the **Child Health Summary Report** command.
The Child Health Summary Report window displays.
- 5 Deselect the All checkbox to generate a report for a specific child(ren).
The checkmark displays.
- 6 Click on the **OK** button.
The Child Health Summary Report displays.
- 7 Click on the Print button.

- 8 Click on the **Close** button.
The Child Health Summary Report displays.
- 9 Click on the **Cancel** button.
The Health Services window displays.

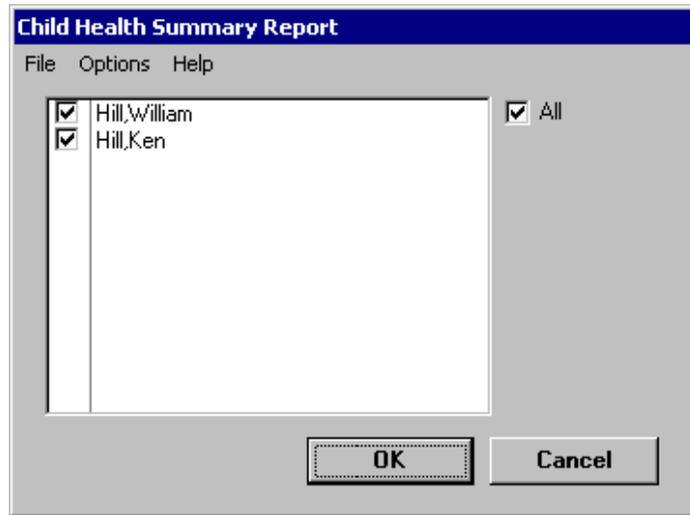


Step-by-Step:
Accessing the Child Health Summary Report via a Case Search
(Without an assigned role in the stage, and assigned the MAINT HEALTH or VIEW HEALTH Business Function)

- 1 Click on the **CASE** button on the CONNECTIONS Toolbar.
The Case Search Criteria window displays.
- 2 Enter the Case ID number in the **Case ID** field (or the Stage ID number in the **Stage ID** field).
- 3 Click on the **Search** button.
The Case List displays with the only case that matches the search criteria.
- 4 Select the case from the *Case List*.
*The **Summary** button enables.*
- 5 Click on the **Summary** button.
The Case Summary window displays.
- 6 Select the FSS stage from the *Case Summary* window.
- 7 Click on the **Options** menu, select the **Stage Maint.** menu item.
- 8 Select the **Maintain Health** command.
The Health Services window displays.
- 9 With a child selected, click on the **Reports** menu and select the **Child Health Summary Report** command.
The Child Health Summary Report displays.
- 10 Deselect the All checkbox to generate a report for a specific child(ren).
The checkmark displays.
- 11 Click on the **OK** button.
The Child Health Summary Report displays.
- 12 Click on the **Print** button.
- 13 Click on the **Close** button.
The Child Health Summary Report displays.
- 14 Click on the **Cancel** button.
The Health Services window displays.



You can also search by Case Name; however, when searching by Case Name, the search criteria must **exactly** match the CONNECTIONS Case Name in order for the search to return a match. Other names in the Case Composition for that case will not return a match (e.g., if a case is named after Sandra Connors, her daughter Mary will be included in the Case Composition, but will not return a match if the Case Search uses Mary's name as the search criteria.)



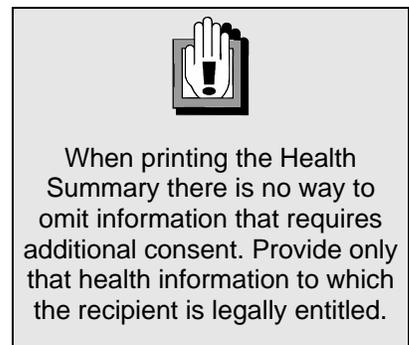
The report contains a header, footer, child detail information, and health summary information. The header will be populated with information in the following fields:

- Report title
- Sensitive Case indicator
- Confidential labels
- Case Name
- Case ID
- Case Initiation Date
- Stage Name
- Stage ID
- Report Date
- District of the Case Manager
- District/Agency of the Case Planner

Other child specific information including the child’s name, person ID, CIN, gender, date of birth and age are system populated on the Child Detail section of the report. When no information exists for a section “No Data Available” will display. The following statement displays at the end of the each Child Detail section:

“This report represents the child’s current health status. Additional information may be available.”

The Health Summary section contains all active non-end dated medical information from the Health Services component. Most of the information displayed contains only non end-dated entries but in some cases an end-date will display if it contains a future date. The information below provides details regarding the type of information pulled into the Health Summary section:



Child Health Info

The **Allergies** section will only display items that are open (non end dated) and valid.
 The **Medication** section and **Durable Medical Equipment** section will only display valid items that are open (non end dated) or have an end date in the future.
 The **Hospitalizations** section will only display valid items that are open (non end dated) or have an end date within the past year.

Clinical Appointments	The Clinical Appointments section will only display the most recent valid item in each domain.
Early Intervention	The Early Intervention sub-section of Health Summary will only display valid entries in the history grid for children less than four years of age.
Biological Family Health information	The Biological Family Health information section contains any health conditions and their specifics for all the members of the family. It also contains responses to health questions for the mother. If the answer is yes, the specifics column will be populated with details.
HIV Risk Assessment	The HIV Risk Assessment sub-section will display (on a separate page) the most recent valid assessment. Additionally, the HIV Risk Assessment information must include the HIV re-disclosure warning.

Other Health Services Outputs

When children enter foster care, authorization must be obtained to provide medical services and to receive documentation of services provided. There are three basic types of consent:

- Consent for routine and emergency health services, (also called Medical Authorization);
- Consent to release health information; and
- Informed consent for non-routine care and services.

CONNECTIONS provides two forms (Authorization to Release Foster Child's Health Records and the Request for Past Medical and Psychological/Psychiatric Health Records) to assist in obtaining medical records for a child in foster care.

Once signed by the child's parent/guardian or legally authorized person, the child's medical records may be released from the health provider to the agency or district, and provides legal references to clarify the authority of the district/agency to request and receive the records.

The form is available for open and closed CWS and CCR stages. It can be accessed by anyone with a current or past role in the stage. The various fields on the output will pre-fill child's demographic information, the name of the case manager's district and the user's agency; other fields require manual completion.



For more information on Health Consents refer to Chapter 6 of the Health Services Manual at www.ocfs.state.ny.us/main/sppd/health_services/manual.asp



When a genuine medical emergency arises before this consent is obtained, emergency treatment can still be provided according to Public Health Law section 2504 which states no consent is needed.



Step-by-Step: Generating the Authorization to Release Foster Child's Health Records Form

- 1 Click on the **WORK** button on the CONNECTIONS Toolbar.
The Assigned Workload displays.
- 2 Select the appropriate FSS stage and click on the **Tasks...** button.
The Family Services Stage window displays.
- 3 Click on the **Health Services** tab.
The Health Services window displays.
- 4 With a child selected in the Child List grid, click on the **Reports** menu and select the **Authorization to Release Foster Child's Health Records** command.
The Authorization to Release Foster Child's Health Records form displays.
- 5 Click on the **Print** button to print the report.
- 6 Click on the **Close** button.
The Health Services window displays.



Step-by-Step:

Generating the Authorization to Release Foster Child's Health Records Form
(Workers in an agency designated as responsible without an assigned role in the stage, and assigned the MAINT HEALTH or VIEW HEALTH Business Function)

- 1 Click on the **CASE** button on the CONNECTIONS Toolbar.
The Case Search Criteria window displays.
- 2 Enter the Case ID number in the **Case ID** field (or the Stage ID number in the **Stage ID** field).
- 3 Click on the **Search** button.
The Case List displays with the only case that matches the search criteria.
- 4 Select the case from the *Case List*.
*The **Summary** button enables.*
- 5 Click on the **Summary** button.
The Case Summary window displays.
- 6 Select the FSS stage from the *Case Summary* window.
- 7 Click on the **Options** menu and select the **Event List...** command.
The Event List displays for the selected stage.
- 8 Click on the **Family Services Stage Open** command.
*The **Detail** button enables.*
- 9 Click on the **Detail** button.
The Family Services Stage window displays.
- 10 Click on the **Health Services** tab.
The Health Services window displays.
- 11 With a child selected, click on the **Reports** menu and select the **Authorization to Release Foster Child's Health Records** command.
The Authorization to Release Foster Child's Health Records form displays.
- 12 Click on the **Print** button to print the report.
- 13 Click on the **Close** button.
The Health Services window displays.



Workers in an agency designated with health responsibility and the Business Function ACCESS ALL IN DISTRICT or ACCESS ALL IN AGENCY must be assigned the MAINT HEALTH or VIEW HEALTH Business Function in order to access health information in a Family Services Stage. Access to Health Information should be allowed only to those with an identifiable and supportable need to know.



You can also search by Case Name; however, when searching by Case Name, the search criteria must **exactly** match the CONNECTIONS Case Name in order for the search to return a match. Other names in the Case Composition for that case will not return a match (e.g., if a case is named after Sandra Connors, her daughter Mary will be included in the Case Composition, but will not return a match if the Case Search uses Mary's name as the search criteria.)

The Request for Past Medical Records and Psychological/Psychiatric form, serves as a cover sheet to the authorization form. It identifies the information requested and the regulatory authority for the request. This form may be accessed by a worker with the Case Manager or Case Planner role in a stage or by anyone designated with health responsibility by selecting the **Medical Records Request Form** command on the **Reports** menu. The form will generate for open and closed CWS and CCR stages.

Similar to the others, these forms will contain space in the header to allow for letterhead usage. The form also provides information on the NYS regulation supporting the request and a checkbox list of the types of medical and psychological/psychiatric records requested. The child's demographic information will pre-fill on the form. Additionally, the local district or agency name will pre-fill on the form when the worker signed into CONNECTIONS is from that local district or agency.



See Appendix H for a sample of the Request for Past Medical and Psychological/Psychiatric Records Form.



Step-by-Step: Generating the Request for Past Medical Records and Psychological/Psychiatric Form

- 1** Click on the **WORK** button on the CONNECTIONS Toolbar.
The Assigned Workload displays.
- 2** Select the appropriate FSS stage and click on the **Tasks...** button.
The Family Services Stage window displays.
- 3** Click on the **Health Services** tab.
The Health Services window displays.
- 4** With a child selected, click on the **Reports** menu and select the **Request for Past Medical Records and Psychological/Psychiatric** command.
The Request for Past Medical Records and Psychological/Psychiatric form displays.
- 5** Click on the **Print** button to print the report.
- 6** Click on the **Close** button.
The Health Services window displays.



Step-by-Step:
Generating the Request for Past Medical Records and Psychological/Psychiatric Form
(Workers in an agency designated as responsible without an assigned role in the stage, and assigned the MAINT HEALTH or VIEW HEALTH Business Function)

- 1 Click on the **CASE** button on the CONNECTIONS Toolbar.
The Case Search Criteria window displays.
- 2 Enter the Case ID number in the **Case ID** field (or the Stage ID number in the **Stage ID** field).
- 3 Click on the **Search** button.
The Case List displays with the only case that matches the search criteria.
- 4 Select the case from the *Case List*.
*The **Summary** button enables.*
- 5 Click on the **Summary** button.
The Case Summary window displays.
- 6 Select the FSS stage from the *Case Summary* window.
- 7 Click on the **Options** menu and select the **Event List...** command.
The Event List displays for the selected stage.
- 8 Click on the **Family Services Stage Open** command.
*The **Detail** button enables.*
- 9 Click on the **Detail** button.
The Family Services Stage window displays.
- 10 Click on the **Health Services** tab.
The Health Services window displays.
- 11 With a child selected, click on the **Reports** menu and select the **Request for Past Medical Records and Psychological/Psychiatric** command.
The Request for Past Medical Records and Psychological/Psychiatric form displays.
- 12 Click on the **Print** button to print the report.
- 13 Click on the **Close** button.
The Health Services window displays.



Workers with the appropriate security based on designated Agency Access (assigned ACCESS ALL IN DISTRICT) must be assigned the MAINT HEALTH or VIEW HEALTH Business Function in order to access health information in a Family Services Stage. Access to Health Information should be allowed only to those with an identifiable and supportable need to know.

Resources

Online Help

Online Help will be updated to reflect enhancements made to the CONNECTIONS system in Build 18.9. The CONNECTIONS Online Help feature provides descriptions for various windows, as well as step-by-step instructions for common tasks. You can access Online Help at any time, from any window in CONNECTIONS. There are different ways to access Online Help: you can click on the **Help** menu in CONNECTIONS or you can press the **F1** key on your keyboard to access context-sensitive Online Help.

The **Contents**, **Index** and **Search** tabs in Online Help allow you to search for and navigate to the topic(s) you need help on.

Updates to Online Help content and functionality in CONNECTIONS are ongoing. As part of recent updates, new Online Help functionality has been added for Family Services Stage windows, as well as *Child Protective Record Summary* windows and *Foster and Adoptive Home Record Summary* windows. When you click on **Help** from any of those windows, the drop-down Help menu displays. For example, from the *Progress Notes* window, clicking on **Help** displays **Progress Notes Help** and from the *Child Protective Record Summary* window, clicking on **Help** displays **CPRS Help**.



Step-by-Step: Accessing Online Help

- 1 Click on the **Help** menu on the CONNECTIONS Toolbar.

The following list of commands displays:

Contents	<i>A table of contents for the help facility with links to major sections.</i>
How Do I?	<i>Step-by-instructions to help you complete tasks using CONNECTIONS.</i>
Window Descriptions	<i>Descriptions of windows in CONNECTIONS, along with information on various fields.</i>
DSS Policy	<i>Online OCFS policy handbooks (under revision).</i>
Help On This Window	<i>Window description help for the window you are on.</i>
Help for Help	<i>Instructions on how to use the help functionality.</i>
About CONNECTIONS	<i>Information about the current CONNECTIONS version and build.</i>

- 2 Click on a command from the **Help** menu.
*The window related to your selection displays. In some cases, you will need to make another selection in that window to obtain instructions. At the top of each window, you'll see additional buttons and menus. Use the **Search** button to search for specific information in the Help function and use the **Back** button to return to windows you've just visited in Help. The **Glossary** button opens a list of important CONNECTIONS terms and the **Print** button allows you to print Help information.*
- 3 When you're done reviewing information in Help, close each *Help* window by clicking on the **Close** button (☒) in the top right corner of the window.
The system returns to the window you were using when you accessed Help.

The Enterprise Help Desk

The New York State Office for Technology (NYS OFT) Enterprise Help Desk staff are available to answer basic questions related to your equipment, or to solve problems you're having with the CONNECTIONS application. If they cannot solve your problem, they will record your information and forward it to others who can.

Your agency may have procedures in place for contacting the Help Desk. Check with your supervisor before you call.

The Help Desk is staffed 24 hours a day, seven days a week. The telephone number is:

1-800-NYS-1323
(1-800-697-1323)

When you call the Help Desk with a problem, you will be given a ticket number to use for tracking your issue and its resolution. Keep a record of this number; you will need it for any follow-up conversations with the Help Desk.

The OCFS CONNECTIONS Intranet Site

A variety of training-related materials are available from the OCFS CONNECTIONS intranet site (<http://ocfs.state.nyenet/connect/>), as well as from the Public Folders in Microsoft Outlook. The intranet site and public folders contain a wealth of information related to various aspects of CONNECTIONS, including training schedules, Alerts and Notices, Step-by-Step Guides (including the *CONNECTIONS Case Management Step-By-Step Guide*), Job Aids and Frequently Asked Questions (FAQs).



Step-by-Step: Accessing the OCFS CONNECTIONS Intranet Site

- 1 From your local desktop, double-click on the **Internet Explorer** icon.
- 2 If the browser does not display the OCFS intranet site automatically, enter *http://ocfs.state.nyenet* into the browser's address line and press the **Enter** key on your keyboard.
The OCFS intranet home page displays.
- 3 Click on the **CONNECTIONS** link.
The CONNECTIONS home page displays.
- 4 Click on a topic to access information.
*For access to various Step-by-Step Guides and Job Aids, click on the **Step-by-Step/Job Aids/Tips** link.*
- 5 To close Internet Explorer, click on the **File** menu and select **Close**.

**Appendix A:
Child Health Info. Tab
Medical Lists**

Allergies Section

The following table provides a complete list of all Categories and Allergens on the **Child Health Info.** tab:

Category	Allergen
Food	<ul style="list-style-type: none"> • Cashews • Eggs • Fish • Milk Products • Peanuts • Shellfish • Soy • Strawberries • Tomatoes • Walnuts • Wheat • Other (specify)
Environmental	<ul style="list-style-type: none"> • Ants • Bees • Birds • Cats • Dogs • Dust • Dust mites • Latex • Mildew • Mold • Pollen • Trees/Grass/Flowers • Other (specify)
Medication	<ul style="list-style-type: none"> • Codeine • Iodine • Novocaine • Penicillin • Sulfa drugs • Other (specify)

Durable Medical Equipment Section

The following list provides all possible equipment selections:

- Adaptive Device
- Apnea Monitor
- Assistive Technology
- Asthma Inhaler
- Brace, body
- Brace, limb
- Cane
- Cervical Collar
- Corrective Footwear
- Crutches
- Epipen
- Eyeglasses or Contact Lenses
- Hearing Aids
- Helmet
- Hospital Bed
- Nebulizer
- Prosthetic Device
- Splint
- Walker
- Wheel Chair
- Other (specify)

**Appendix B:
Clinical Appointment Tab
Medical Lists**

The following table provides a complete list of Appointment types, Diagnosis and Treatment Recommendations for a selected Domain Type:

Domain Type	Appointment Type	Diagnosis	Treatment Recommendation
Dental	Diagnosis at Intake	Abscess	Bridge/Dentures
	Emergency Care	Bruxism (grinding teeth)	Endodontics (root canal)
	Initial Assessment	Cavities	Extraction (oral surgery)
	Preventive	Cleft Lip or Palate	Fillings
	Reassessment	Fractured Tooth	Orthodontia
	Treatment	Gingivitis (periodontal disease)	Prophylaxis (cleaning, fluoride)
		Gingival Overgrowth	Sealants
		Impacted 3rd molars (wisdom teeth)	X-rays
		Malocclusion, mild, moderate	
		Malocclusion, severe	
		Missing Tooth	
		Normal Teeth and Supporting Structures	
		Pain	
Periodontal Disease (gingivitis)			
Root Canal Therapy needed			
Tooth Discoloration			
Tooth Eruption			
Developmental	Diagnosis at Intake	Asperger's Disorder	Audiology
	Emergency Care	Autistic Disorder	Durable Medical Equipment
	Follow-up	Impaired Activities of Daily Living	Education/Training for Caregiver
	Initial Assessment	Cerebral Palsy	Exercise
	Reassessment	Down Syndrome	Occupational Therapy
	Treatment	Epilepsy/Seizure Disorder	Physical Therapy
		Fetal Alcohol Effect	Referral to OMRDD Services
		Fetal Alcohol Syndrome	Special Education/Tutoring
		Fine Motor Delay/impairment	Speech Therapy
		Gross Motor Delay/impairment	Vocational Therapy/Counseling
		Learning Disabled (specify)	
		Mental Retardation, mild	

Domain Type	Appointment Type	Diagnosis	Treatment Recommendation
		Mental Retardation, moderate Mental Retardation, severe Mental Retardation, profound Mental Retardation, severity not specified Narcolepsy Neurological Impairment Pervasive Developmental Disorder Prader-Willi Syndrome Seizure Disorder/Epilepsy Sensory Impairment Social/Emotional Delay/impairment Speech/Language Delay/impairment Tourette's Disorder/Syndrome Traumatic Brain Injury Well Child	
Mental Health	Crisis Intervention Diagnosis at Intake Follow-up Initial Assessment Medication Monitoring Reassessment Treatment	Acute Stress Disorder Adjustment Disorder with Depressed Mood Adjustment Disorder with Anxiety Adjustment Disorder with Mixed Anxiety and Depressed Mood Adjustment Disorder with Disturbance of Conduct Adjustment Disorder with Mixed Disturbance Emotions and Conduct Adjustment Disorder, Unspecified Agoraphobia without History of Panic Disorder Anxiety, not otherwise	Case Management Day Treatment Education/Training for Caregiver Inpatient Treatment Lab work Medication Mentoring Referral to OMH Services Therapy- Art Therapy- Family Therapy- Group Therapy- Individual Therapy- Play Wraparound Services

Domain Type	Appointment Type	Diagnosis	Treatment Recommendation
		specified Anorexia Nervosa Antisocial Personality Disorder Attention Deficit Hyperactivity Disorder, predominantly hyperactive Attention Deficit Hyperactivity Disorder, predominantly inattentive Attention Deficit Hyperactivity Disorder, combined Attention Deficit Hyperactivity Disorder, not otherwise specified Asperger's Disorder Autistic Disorder Avoidant Personality Disorder Bipolar I disorder (Depressive and Manic Episodes) Bipolar II Disorder (Depressive and Hypomanic Episodes) Borderline Personality Disorder Brief Psychotic Disorder Bulimia Nervosa Child or Adolescent Antisocial Behavior Childhood Disintegrative Disorder Cognitive Disorder Communication Disorder, expressive language Communication Disorder, mixed receptive-expressive language Communication	

Domain Type	Appointment Type	Diagnosis	Treatment Recommendation
		Disorder, phonological Communication Disorder, stuttering Communication Disorder, not otherwise specified Conduct Disorder, Childhood-Onset Type Conduct Disorder, Adolescent-Onset Type Conduct Disorder, Unspecified Onset Cyclothymic Disorder Delusional Disorder Dementia Due to HIV Infection Dependent Personality Disorder Depersonalization Disorder Depressive Disorder, dysthymic Depressive Disorder, major Depressive Disorder, not otherwise specified Developmental Coordination Disorder Disruptive Behavior Disorder, not otherwise specified Dissociative Disorder, not otherwise specified Dissociative Identity Disorder (multiple personality disorder) Eating Disorder, not otherwise specified Elimination Disorder, enuresis (bed wetting) Elimination Disorder, encopresis (soiling) Factitious Disorder Gambling, pathological Gender Identity	

Domain Type	Appointment Type	Diagnosis	Treatment Recommendation
		Disorder Generalized Anxiety Disorder Histrionic Personality Disorder Hypochondriasis Identity Problem Impulse Control Disorder, not otherwise specified Intermittent Explosive Disorder Kleptomania (stealing) Mental Retardation, mild Mental Retardation, moderate Mental Retardation, severe Mental Retardation, profound Mental Retardation, severity not specified Mood Disorder, not otherwise specified Mood Disorder, postpartum onset Mutism, Selective Narcissistic Personality Disorder Neglect of Child Obsessive Compulsive Disorder Obsessive Compulsive Personality Disorder Oppositional Defiant Disorder Panic Disorder with Agoraphobia Panic Disorder without Agoraphobia Paranoid Personality Disorder Paranoid Type of	

Domain Type	Appointment Type	Diagnosis	Treatment Recommendation
		Schizophrenia Parent-Child Relational Problem Personality Disorder, not otherwise specified Pervasive Developmental Disorder Physical Abuse of Child Pica Postpartum onset, Mood Disorder Posttraumatic Stress Disorder Posttraumatic Stress Disorder, Acute Posttraumatic Stress Disorder, Chronic Posttraumatic Stress Disorder with Delayed Onset Psychotic Disorder, not otherwise specified Pyromania (fire setting) Reactive Attachment Disorder of Infancy or Early Childhood Reactive Attachment Disorder of Infancy or Early Childhood, Inhibited Type Reactive Attachment Disorder of Infancy or Early Childhood, Disinhibited Type Relational Problem, Not Otherwise Specified Schizophrenia, Paranoid Type Schizophrenia, Disorganized Type Schizophrenia, Catatonic Type Schizophrenia, Undifferentiated Type Schizophrenia, Residual	

Domain Type	Appointment Type	Diagnosis	Treatment Recommendation
		Type Separation Anxiety Disorder Sexual Abuse of Child Sexual Disorder, Exhibitionism Sexual Disorder, Fetishism Sexual Disorder, Frotteurism Sexual Disorder, Masochism Sexual Disorder, Pedophilia Sexual Disorder, Sadism Sexual Disorder, Transvestic Sexual Disorder, not otherwise specified Sibling Relational Problem Sleep Disorder, Insomnia Sleep Disorder, Hypersomnia Sleep Disorder, Narcolepsy Sleep Disorder, Nightmares Sleep Disorder, Sleep Terror Sleep Disorder, Sleepwalking Sleep Disorder, not otherwise specified Social Phobia (Social Anxiety Disorder) Somatoform Disorder Stereotypic Movement Disorder Stereotypic Movement Disorder, with self-injurious behavior Substance Induced	

Domain Type	Appointment Type	Diagnosis	Treatment Recommendation
		Mood Disorder Substance Induced Psychosis Substance Related Disorder, not otherwise specified Tic Disorder, chronic motor or vocal tic Tic Disorder, not otherwise specified Tourette's Disorder/Syndrome Trichotillomania (hair pulling) Well child	
Physical/Medical	Diagnosis at Intake Emergency Care Follow-up Initial Assessment Medication Monitoring Reassessment Sick child Well child	Acne Allergies (environmental, food, medication) (specify) Aneurysm Anorexia Nervosa Apnea Appendicitis Arthritis Anemia Asthma Mild (no treatment) Asthma Moderate (occasional treatment) Asthma Severe (daily treatment) Blind/Visually Impaired Bronchitis Bronchiolitis Bulimia Nervosa Burns, acute minor Burns, acute extensive Burns, chronic minor scarring Burns, chronic extensive scarring Cancer (other than Leukemia, specify)	Durable Medical Equipment Education/Training for Caregiver Environmental Changes Exercise Hospitalization Imaging (CAT scan, MRI, ultrasound, X-ray) Lab work Medication Physical Therapy Referral to Specialist Routine Follow-up Special Diet Surgery- Inpatient Surgery- Outpatient

Domain Type	Appointment Type	Diagnosis	Treatment Recommendation
		Celiac Disease Cerebral Palsy Cervical Dysplasia Chicken Pox Child Abuse/Neglect Chlamydia Cholesterol elevated (hyperlipidemia) Cleft Lip or Palate Club Foot Colic Concussion Congenital Heart Disease, mild Congenital Heart Disease, disabling Conjunctivitis Coxsackie Virus Crohn's Disease Croup Cystic Fibrosis Deaf/Hearing Impaired Dehydration Diabetes Type I Diabetes Type II Diarrhea Disfigurement Down Syndrome Drug Exposed Newborn (Positive Toxicology, Drug Withdrawal, In Utero Drug Exposure) Dwarfism Dysmenorrhea Eczema Emphysema Encephalitis Encopresis Enuresis Epilepsy/Seizure Disorder	

Domain Type	Appointment Type	Diagnosis	Treatment Recommendation
		Failure to Thrive Fetal Alcohol Effect Fetal Alcohol Syndrome Fifth Disease Flat Feet Fracture (specify location) Fragile X Syndrome Gastroesophageal Reflux (Acid Reflux) Genital Herpes Genital Warts Gonorrhea Heart Disease Hemophilia Hernia Hepatitis (non-A, non-B, non-C) Hepatitis A Hepatitis B Hepatitis C HIV Infection Human Papilloma Virus (HPV) Hypertension Impetigo Kidney Disease Lead Poisoning Leukemia Lice Liver Disease Lupus Malnutrition Measles Meningitis Migraines Miscarriage Mononucleosis Multiple Sclerosis Mumps	

Domain Type	Appointment Type	Diagnosis	Treatment Recommendation
		Muscular Dystrophy Neurofibromatosis Neurological disorder Obesity Osteoporosis Otitis Media (ear infection) Pap Smear – Abnormal Pelvic Inflammatory Disease Pertussis (Whooping Cough) Pneumonia Pregnancy, non-complicated Pregnancy, complicated Premature Infant Retinal Hemorrhage Rheumatoid Arthritis, Juvenile Ringworm Roseola Rubella (German Measles) Scabies Scleroderma Scoliosis Seizure Disorder/Epilepsy Sexually Transmitted Diseases (not Chlamydia, Gonorrhea, Genital Herpes, Syphilis, HPV or HIV) Shaken Baby Syndrome Sickle Cell Disease Sickle Cell Trait Sinusitis Spina Bifida Sprain Strep Throat	

Domain Type	Appointment Type	Diagnosis	Treatment Recommendation
		Stroke Syphilis Tay Sachs Disease Tetanus Thrush Tonsillitis Tracheotomy Traumatic Brain Injury Tuberculosis, active disease Tuberculosis, latent infection Turner's Syndrome Ulcer Ulcerative colitis Undescended testicles Upper Respiratory Infection (URI) Urinary Tract Infection (UTI) Well Child	
Substance Abuse	Crisis Intervention Diagnosis at Intake Follow-up Initial Assessment Reassessment Treatment	Alcohol Abuse Alcohol Dependence Amphetamine Abuse Amphetamine Dependence Cannabis (Marijuana) Abuse Cannabis (Marijuana) Dependence Cocaine Abuse Cocaine Dependence Hallucinogen Abuse Hallucinogen Dependence Inhalant Abuse Inhalant Dependence Nicotine Abuse Nicotine Dependence No Substance Abuse Suspected	Education/Prevention Inpatient Management of Withdrawal/Detox – over laid Inpatient Management of Withdrawal Outpatient Management of Withdrawal/Detox Outpatient Substance Abuse Treatment, Group - overlaid Therapy Group Outpatient Substance Abuse Treatment, Individual – overlaid Therapy – Individual Outpatient Treatment, Methadone Referral to OASAS Services Residential Substance abuse Treatment, Long-term

Domain Type	Appointment Type	Diagnosis	Treatment Recommendation
		Opioid Abuse Opioid Dependence Phencyclidine Abuse Phencyclidine Dependence Poly-substance Abuse Poly-Substance Dependence Sedative, Hypnotic or Anxiolytic Abuse Sedative, Hypnotic or Anxiolytic Dependence	Residential Substance Abuse Treatment, Mother and Child Residential Substance abuse Treatment, Short-term Substance Abuse Education/Prevention – overlaid Education/Prevention Therapy- Group Therapy- Individual

**Appendix C:
Bio Family Info. Tab
Conditions List**

Conditions List

The Conditions field includes the following:

<ul style="list-style-type: none">• Alcohol Abuse• Alcohol Dependence• Allergies (specify)• Aneurysm• Asperger's Disorder• Asthma• Autism• Blind/visually impaired• Cancer (specify)• Celiac Disease• Cerebral Palsy• Cleft Lip or Palate• Cystic Fibrosis• Deaf/Hearing Impaired• Diabetes Type I• Diabetes Type II• Down Syndrome• Dwarfism• Eczema• Emphysema• Epilepsy/ Seizure Disorder• Fragile X Syndrome• Gingivitis (periodontal disease)• Heart Disease• Hemophilia• High Cholesterol• Hypertension (high blood pressure)• Kidney Disease• Learning Disabled (specify)	<ul style="list-style-type: none">• Liver Disease• Lupus• Mental Illness (specify)• Mental Retardation• Migraines• Motor Delay/impairment• Multiple Sclerosis• Muscular Dystrophy• Narcolepsy• Neurofibromatosis• Neurological Impairment• Obesity• Osteoporosis• Pervasive Developmental Disorder• Prader-Willi Syndrome• Scleroderma• Scoliosis• Seizure Disorder/Epilepsy• Sensory Impairment• Sickle Cell Disease/Trait• Social/Emotional Delay/impairment• Speech/Language Delay/impairment• Spina Bifida• Stroke• Substance Abuse• Substance Dependence• Tay-Sachs Disease• Tourette's Disorder/Syndrome• Ulcer
--	---

Appendix D: HIV Risk Assessment Scenarios

Scenarios ► Questions ▼	1	2	3	4	5	6	7	8	9	
1 Is this a newborn screening?	= Yes ▪ Save is enabled	▪ = No ▪ Question 2 is displayed	▪ = No ▪ Question 2 is displayed	▪ = No ▪ Question 2 is displayed	▪ = No ▪ Question 2 is displayed	▪ = No ▪ Question 2 is displayed	▪ = No ▪ Question 2 is displayed	= No ▪ Question 2 is displayed	= No ▪ Question 2 is displayed	
2 Does child have capacity to consent to HIV test?	Fields are not displayed. ↓	▪ = No ▪ Question 3 is displayed	▪ = No ▪ Question 3 is displayed	= Yes ▪ Question 3 is displayed	= Yes ▪ Question 3 is displayed	= Yes ▪ Question 3 is displayed	= Yes ▪ Question 3 is displayed	= Yes ▪ Question 3 is displayed	= Yes ▪ Question 3 is displayed	
3 Does child have HIV risk factors?		= No ▪ HIV Risk Assessment is complete ▪ Save is enabled	= Yes ▪ Question 6 is displayed	= No ▪ Question 4 is displayed	= No ▪ Question 4 is displayed	= No ▪ Question 4 is displayed	= Yes ▪ Question 4 is displayed	= Yes ▪ Question 4 is displayed	= Yes ▪ Question 4 is displayed	
4 Will child consent to test?		Fields are not displayed.	Fields are not displayed.	= No ▪ HIV Risk Assessment is complete ▪ Save is enabled	= Yes ▪ Question 5 is displayed	= Yes ▪ Question 5 is displayed	= Yes ▪ Question 5 is displayed	= Yes ▪ Question 5 is displayed	= No ▪ HIV Risk Assessment is completed ▪ Save is enabled	
5 Child consents to:		Fields are not displayed.	Fields are not displayed.	Fields are not displayed.	= Anonymous ▪ HIV Risk Assessment is complete ▪ Save is enabled	= Confidential ▪ Save is enabled	= Confidential ▪ Save is enabled	= Anonymous ▪ HIV Risk Assessment is completed ▪ Save is enabled	Fields are not displayed.	
6 Legal consent obtained from:		↓	↓	↓	↓	Field is not displayed.	Field is not displayed.	Field is not displayed.	Field is not displayed.	
7 HIV Test frame		Enabled ▪ HIV Risk Assessment is complete (After entering Date and Results)	<i>Not Enabled</i>	Enabled ▪ HIV Risk Assessment is complete (After entering Date and Results)	<i>Not Enabled</i>	<i>Not Enabled</i>	<i>Enabled</i> ▪ HIV Risk Assessment is complete (After entering Date and Results)	<i>Enabled</i> ▪ HIV Risk Assessment is complete (After entering Date and Results)	<i>Not Enabled</i>	<i>Not Enabled</i>
				Save Enabled (After selection)						↓

Appendix E: Child Health History Report

Case Name:
Case ID:
Case Initiation Date:
District of the Case Manager:

Stage Name:
Stage ID:
Report Date:
District/Agency of the Case Planner:

CHILD DETAIL

Name: Last Name, First Name MI Person ID: 99999999 Sex: XXXXXX DOB: MM/DD/YYYY Age: XX CIN: XXXXXXXXXX

This report represents the child's current health status. Additional information may be available.

CHILD HEALTH HISTORY DETAIL

Medicaid Status	Medicaid Number	After Hours Agency Contact	After Hours Agency Contact	Primary Care / Medical Home	Primary Care / Medical Home Address	Primary Care / Medical Home
Eligible-Card	1234567	Kelly Standard	(315) 555-1234	Greene, Terrence	1333 Westchester Rd, Rochester, NY 12084	(315) 555-3214

Child Health Information

Allergies

<u>Allergy Type</u>	<u>Allergen</u>	<u>Specifics</u>	<u>Start Date</u>	<u>End Date</u>
<u>Environmental</u>	<u>Milk Products</u>		<u>01/19/2005</u>	<u>10/19/2005</u>

This information has been disclosed to you from confidential records which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the appropriate specific written consent from a person authorized to provide such consent, or as otherwise permitted by law. Any unauthorized further disclosures in violation of State Law may result in a fine or jail sentence or both.

Case Name:
Case ID:
Case Initiation Date:
District of the Case Manager:

Stage Name:
Stage ID:
Report Date:
District/Agency of the Case Planner:

Medications

Medication		Start Date	End Date
Ceftin	Bronchitis	02/12/2005	
Airett	Respiratory	10/15/2005	12/25/2005

Durable Medical Equipments

Equipment	Specifics	Start Date	End Date
Eye glasses		08/15/2004	
Crutches		9/10/2005	12/31/2005

Hospitalizations (End date within past year)

Hospital	City/Town	Reason	Psy	Start Date	End Date
Mercy Hospital	Rochester	Felt very ill	N	10/1/2005	10/1/2005

Case Name:
 Case ID:
 Case Initiation Date:
 District of the Case Manager:

Stage Name:
 Stage ID:
 Report Date:
 District/Agency of the Case Planner:

Clinical Appointments

Domain Type	Appointment Type	Appointment Date	Diagnoses	Diagnosis	Provider	Treatment Recommendations
Physical/Medical		12/12/2004				

Early Interventions

Evaluations

Referral Date	Evaluation	Classification / Disability Type
12/12/2004	12/12/2004	Developmental Delay

Program History

Program Start Date	Program End Date	Program Name	Program Contact Person	Contact Number	Date Updated	Updated By	Service Types
12/12/2004	12/31/2004			(999) 999-9999	12/31/2004		

This information has been disclosed to you from confidential records which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the appropriate specific written consent from a person authorized to provide such consent, or as otherwise permitted by law. Any unauthorized further disclosures in violation of State Law may result in a fine or jail sentence or both.

Case Name:
Case ID:
Case Initiation Date:
District of the Case Manager:

Stage Name:
Stage ID:
Report Date:
District/Agency of the Case Planner:

Biological Family Health Information

Relationship	Date of Birth	Age at Child's Birth	Race/Ethnicity	Conditions	Specifics
Mother	12/12/1965	xx	xxxxxxx-xxxxxxx		
Father					
Sibling					
Relative					

Specifics

Did the mother receive pre-natal care? <yes/no/unknown>

Did the mother take any medications during pregnancy? <yes/no/unknown>

Did the mother have any illnesses during pregnancy? <yes/no/unknown>

Did the mother use drugs/alcohol during pregnancy? <yes/no/unknown>

Has the child been regularly exposed to tobacco, including pregnancy? <yes/no/unknown>

Is the mother deceased? <yes/no>
If yes, age at death:

Is the father deceased? <yes/no>
If yes, age at death:

Case Name:
 Case ID:
 Case Initiation Date:
 District of the Case Manager:

Stage Name:
 Stage ID:
 Report Date:
 District/Agency of the Case Planner:

HIV Risk Assessment

Date of Assessment	Does child have capacity to consent to test?	Was child HIV exposed at birth?	Does child have HIV Risk Factors?	Will child consent to HIV test?	Test Classification	Consent to test obtained from	Date of HIV test	Test Result	Result Confirmed with Medical Professional?
12/12/2004	<yes/no>	<yes/no>	<yes/no>	<yes/no>	anonymous	<child, parent/LG>	Mm/dd/yyyy	<positive / negative>	<yes/no>
					confidential	<LDSS Commish>			
						<Court>			

HIV Confidentiality Statement

Confidential HIV-related information means any information in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV-related information concerning whether an individual has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify an individual as having one or more such conditions.

Refer to 91-ADM 36 for guidelines on HIV confidentiality. Any disclosure of HIV-related information must include the following Warning Notice:

Warning Notice Against Re-disclosure of confidential HIV-related Information

This information has been disclosed to you from confidential records, which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. Any unauthorized further disclosure in violation of state Law may result in a fine or a jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

This information has been disclosed to you from confidential records which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the appropriate specific written consent from a person authorized to provide such consent, or as otherwise permitted by law. Any unauthorized further disclosures in violation of State Law may result in a fine or jail sentence or both.

Appendix F: Child Health Summary Report

Case Name:
 Case ID:
 Case Initiation Date:
 Local District of the Case Manager:

Stage ID:
 Stage Name:
 Report Date:
 District/Agency of the Case Planner:

Medications

Medication		Start Date	End Date
Ceftin	Bronchitis	02/12/2005	
Airett	Respiratory	10/15/2005	12/25/2005

Durable Medical Equipment

Equipment	Specifics	Start Date	End Date
Eye glasses		08/15/2004	
Crutches		09/10/2005	12/31/2005

Hospitalizations (End date within past year)

Hospital	City/Town	Reason	Psy	Start Date	End Date
Mercy Hospital	Rochester	Felt very ill	N	10/01/2005	

SENSITIVE CASE

CHILD HEALTH SUMMARY REPORT

****WARNING****
 CONFIDENTIAL INFORMATION
 AUTHORIZED PERSONNEL ONLY

This information has been disclosed to you from confidential records which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the appropriate specific written consent from a person authorized to provide such consent, or as otherwise permitted by law. Any unauthorized further disclosures in violation of State Law may result in a fine or jail sentence or both.

Case Name:
Case ID:
Case Initiation Date:
Local District of the Case Manager:

Stage ID:
Stage Name:
Report Date:
District/Agency of the Case Planner:

Clinical Appointments (Most Recent in each Domain)

Domain Type	Appointment Type	Appointment Date	Diagnosis Date	Diagnosis	Provider	Treatment Recommendations
Physical/Medical	Initial	03/26/2004			Mercy Hospital	Physical Therapy, Referral to Specialist
Dental	Diagnosis at Intake		05/26/2004		Better Thoughts	

Early Intervention

Evaluation (Child under 4)

Referral Date	Evaluation	Classification / Disability Type
09/01/2004	10/10/2004	Developmental Delay

Program History (Child under 4)

Program Start Date	Program End Date	Program Name	Contact Person	Contact Number	Date Updated	Updated By	Service Types
10/11/2005		Developing Horizons	Shelly Foster	(518) 432-1236	10/10/2005		Audiology Services, Health Services
10/20/2005	12/01/2005	P's \$ Q's	Frank Lloyd	(212) 236-5698	10/19/2005	Lighthall, Karyn	

This information has been disclosed to you from confidential records which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the appropriate specific written consent from a person authorized to provide such consent, or as otherwise permitted by law. Any unauthorized further disclosures in violation of State Law may result in a fine or jail sentence or both.

Case Name:
Case ID:
Case Initiation Date:
Local District of the Case Manager:

Stage ID:
Stage Name:
Report Date:
District/Agency of the Case Planner:

Biological Family Health Information

Relationship	Date of Birth	Age at Child's Birth	Race/Ethnicity	Conditions	Specifics
Mother	01/01/1982	20			
Father	01/01/1980				
Sibling					
Sibling					
Relative					

Specifics

Did the mother receive pre-natal care? <yes / no / unknown>
 Did the mother take any medications during pregnancy? <yes / no / unknown>
 <yes / no / unknown>
 <yes / no / unknown>
 <yes / no / unknown>

Is the mother deceased? <yes / no>
 If yes, age at death:

Is the father deceased?
 If yes, age at death:

This information has been disclosed to you from confidential records which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the appropriate specific written consent from a person authorized to provide such consent, or as otherwise permitted by law. Any unauthorized further disclosures in violation of State Law may result in a fine or jail sentence or both.

SENSITIVE CASE

CHILD HEALTH SUMMARY REPORT

****WARNING****

Case Name:
Case ID:
Case Initiation Date:
Local District of the Case Manager:

Stage ID:
Stage Name:
Report Date:
District/Agency of the Case Planner:

HIV Risk Assessment (Most Recent)

Date of Last Test: 10/10/2004
Result: Positive
Result confirmed by Medical Professional: Yes

HIV Confidentiality Statement

Confidential HIV-related information means any information in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV-related information concerning whether an individual been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify an individual as having one or more such conditions.

Refer to 91-ADM 36 for guidelines on HIV confidentiality. Any disclosure of HIV-related information must include the following Warning Notice:

Warning Notice Against Re-disclosure of confidential HIV-related Information

This information has been disclosed to you from confidential records, which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. Any unauthorized further disclosure in violation of state Law may result in a fine or a jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

This information has been disclosed to you from confidential records which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the appropriate specific written consent from a person authorized to provide such consent, or as otherwise permitted by law. Any unauthorized further disclosures in violation of State Law may result in a fine or jail sentence or both.

**Appendix G:
Authorization to Release Foster Child's Health Records
Consent Form**

AUTHORIZATION TO RELEASE FOSTER CHILD'S HEALTH RECORDS

Child's Name: Hill, William Date of Birth: 12/23/1993

Date of Entry into Foster Care ___/___/___ Child's Social Security Number: _____

Case# 32700178 Case Name: Hill, Jean Medical Record# (if known) _____

The Health Insurance Portability and Accountability Act ("HIPAA") specifically states that State laws and regulations with respect to the release of health information for minors remain intact. 45 CFR 164.502(g). Consequently, the release of this information is permitted and required under State and Federal law.

. The parent/legal guardian of the above named child signed this consent.

-OR-

. This child is in foster care. This consent is signed by a duly authorized representative of [___<LDSS/Agency>___], an authorized agency in connection with foster care and adoption, signed this consent

-OR-

. [___<LDSS>___] is the child's legal guardian. Thus a duly authorized representative of [___<LDSS>___], an authorized agency in connection with foster care and adoption, signed this consent.

This information has been disclosed to you from confidential records which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the appropriate specific written consent from a person authorized to provide such consent, or as otherwise permitted by law. Any unauthorized further disclosures in violation of State Law may result in a fine or jail sentence or both.

Check As Many As Apply:

Prior Health Information: Title 18 of the New York State Codes Rules and Regulations authorize [<LDSS>] to sign a release for health information pertaining to a child prior to the child's admission into foster care. Specifically, 18 NYCRR 441.22(e) states that "authorization must be requested from the child's parent or guardian for release of the child's past medical records. If written consent for release of such records cannot be obtained, the local social services commissioner may authorize release of such records." [<LDSS >] has been unable to obtain the signed release from the parents.

Psychiatric/psychological reports: N.Y. Mental Hygiene Law § 33.13(7) states that release of these records is permitted to an entity that is authorized to act on the patient's behalf and has a demonstrable need for the information. [<LDSS/Agency>] acts on behalf of the child for health needs. Social Services Law sections 383-b and 398, as well as Title 18 of the NYCRR permit and mandate [<LDSS>] to consent for and provide medical services for children in foster care. Therefore, [<LDSS/Agency>] requires the child's health records.

Current Medical Records: Social Services Law sections 383-b and 398, as well as Title 18 of the NYCRR permit and mandate [<LDSS>] to consent for and provide medical services for children in foster care. Therefore, as the child's personal representative, [<LDSS/Agency>] requires the child's health records.

HIV Related Information: Public Health Law § 2782(1)(h) permits the disclosure of confidential HIV information to "an authorized agency in connection with foster care or adoption." [<LDSS/Agency>] is such an authorized agency. See N.Y. Social Services Law § 371(10), which defines "authorized agency."

This information has been disclosed to you from confidential records which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the appropriate specific written consent from a person authorized to provide such consent, or as otherwise permitted by law. Any unauthorized further disclosures in violation of State Law may result in a fine or jail sentence or both.

Notice regarding HIV Related Information: Confidential HIV Related Information (that is, information related to the Human Immunodeficiency Virus that causes AIDS) is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV. Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release form. If you sign this form, HIV related information can be given to the people listed on the form and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time.

The commissioner of [__<LDSS>_____] has delegated his/her legal authority to request this information. I hereby certify that [__<LDSS/Agency>_____] employs me in the title of: _____ and that I have the proper authority to request these records.

=====

I, _____, hereby authorize _____ to
NAME OF PERSON SIGNING BELOW DOCTOR'S OFFICE/HOSPITAL/CLINIC

disclose specific health information from the records of the above named child to [__<LDSS/Agency>___],
attention: _____

ADDRESS

for the specific purposes of complying with State law and/or ensuring this child receives proper care while in the custody of the Commissioner. The specific information to be disclosed is: _____

=====

SPECIFY MEDICAL INFORMATION REQUESTED INCLUDING DATES OF SERVICE IF KNOWN.

This authorization will expire on final discharge from foster care.

=====

- I understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the next page of this form.
- I further understand that any action taken on this authorization prior to the rescinded date is legal and binding. Moreover, I understand that [__<LDSS/Agency>___] will inform the above named provider that I have rescinded this authorization.

This information has been disclosed to you from confidential records which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the appropriate specific written consent from a person authorized to provide such consent, or as otherwise permitted by law. Any unauthorized further disclosures in violation of State Law may result in a fine or jail sentence or both.

Revocation Section

I do hereby request that this authorization to disclose health information of _____
signed by _____ on ____/____/____ be rescinded effective ____/____/____.
NAME OF PERSON WHO SIGNED RELEASE DATE NAME OF CHILD DATE

I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____/_____/_____
SIGNATURE OF PERSON WHO SIGNED RELEASE DATE PERSONAL REPRESENTATIVE RELATIONSHIP/AUTHORITY
_____/_____/_____
SIGNATURE OF WITNESS DATE

Verbal Revocation Section

I do hereby attest to the verbal request for revocation of this authorization by

_____/_____/_____. The client or personal representative has been
NAME OF CLIENT OR PERSONAL REPRESENTATIVE DATE

informed that any action taken on this authorization prior to the rescinded date is legal and binding.

_____/_____/_____
SIGNATURE OF STAFF DATE WITNESS DATE

Notification Of Provider

I do hereby state that I notified _____ of _____ on ____/____/____
NAME OF PERSON YOU NOTIFIED DOCTOR'S OFFICE/HOSPITAL/CLINIC DATE

that this authorization was revoked. I notified them by (email/telephone) and I (mailed/faxed) a copy of this
revocation section to _____
ADDRESS OR FAX NUMBER

_____/_____/_____
SIGNATURE OF STAFF DATE TITLE

This information has been disclosed to you from confidential records which are protected by State Law. State Law prohibits you from making any further disclosure of this information without the appropriate specific written consent from a person authorized to provide such consent, or as otherwise permitted by law. Any unauthorized further disclosures in violation of State Law may result in a fine or jail sentence or both.

**Appendix H:
Request for Past Medical Records Consent Form**

[LDSS/Agency name, address, telephone or letterhead]

REQUEST FOR PAST MEDICAL AND PSYCHOLOGICAL/PSYCHIATRIC HEALTH RECORDS

Date: ____/____/____

Child Name: Hill,William Birthdate: 12/23/1993 Social Security Number:

Case Name: Hill,Jean Case #: 32700178

Mother's Name: _____

To Whom It May Concern:

The above named child is in the care/custody or custody/guardianship of *Onondaga County Dss* and is currently receiving foster care/group home services.

Title 18 of the New York State Department of Social Services Regulations Section 507.1 mandates that *Onondaga County Dss* maintain a health record for every child in foster care. Section 507.1 also grants the Commissioner authority to obtain the health history of every child in foster care. Pursuant to the New York State Department of Social Services Regulations, this record must include information regarding the health history, current health status, and health care needs of the children in care. As you are one of the child's former health providers, *Onondaga County Dss* requests that you send the following records in compliance with this mandate:

- | | |
|--|--|
| <input type="checkbox"/> Birth records | <input type="checkbox"/> Immunization history |
| <input type="checkbox"/> Family history | <input type="checkbox"/> Chronic illnesses |
| <input type="checkbox"/> Clinic visit records | <input type="checkbox"/> Consultation summaries |
| <input type="checkbox"/> History & physical | <input type="checkbox"/> Hospital admission summaries (medical, psychiatric, surgical) |
| <input type="checkbox"/> Laboratory test results | <input type="checkbox"/> Psychiatric/psychological summaries |
| <input type="checkbox"/> Vision exams | <input type="checkbox"/> Medications (including psychotropics) |
| <input type="checkbox"/> Hearing exams | <input type="checkbox"/> Adaptive devices |
| <input type="checkbox"/> Dental exams/summaries | <input type="checkbox"/> Gyn (include hx pregnancy/abortion) |
| <input type="checkbox"/> Behavioral assessment with formal testing results | <input type="checkbox"/> Developmental assessment with formal testing results |
| <input type="checkbox"/> Other: _____ | |

Please promptly return this form, signed, with the above requested information to:

Onondaga County Dss

Unit/Division/Facility: _____ Phone#: (..) _____

Name: _____

Title: _____

Address: _____

Attached are copies of all records for the above-named child that are in my files.

Name: _____, _____

MD

Signature: _____

Date: ____/____/____