

# Working Together

## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

NYS Office of Children and Family Services

### Appendix C

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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**Note:** Access to New York State laws:

<http://public.leginfo.state.ny.us/menugetf.cgi?COMMONQUERY=LAWS>

Access to Codes, Rules and Regulation of the State of New York:

<http://www.dos.state.ny.us/info/nycrr.htm>

The federal EPSDT guidelines can be accessed at

<http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927> Select Part 5.

**Be sure to consult with your LDSS or voluntary agency counsel on legal matters.**

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HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

*NYS Office of Children and Family Services*

## 10 NYCRR

### PART 80

#### RULES AND REGULATIONS ON CONTROLLED SUBSTANCES

(Statutory authority: Public Health Law, Sections 338, 3300, 3305, 3307, 3308, 3381, 3701(1), (6), art. 33)

#### **80.47 - Institutional dispensers, limited**

(a) Nursing homes, convalescent homes, health-related facilities, adult care facilities subject to the provisions of 18 NYCRR Parts 487, 488 and 490, dispensaries or clinics not qualifying as institutional dispensers in license class 3 shall apply for an institutional dispenser, limited license. Such institutional dispensers qualifying for controlled substances privileges shall obtain a class 3a license from the department.

(b) An institutional dispenser licensed in class 3a may administer controlled substances to patients only pursuant to a prescription issued by an authorized physician or other authorized practitioner and filled by a registered pharmacy; except that controlled substances in emergency medication kits may be administered to patients as provided in section 80.49(d) of this Part; however, controlled substances in emergency medication kits may not be administered to patients in an adult care facility subject to the provisions of 18 NYCRR Parts 487, 488 and 490.

(c) An institutional dispenser, limited, licensed in class 3a, which is operated as an integral and physical part of a facility licensed as a class 3 institutional dispenser may be provided with bulk stocks of controlled substances obtained pursuant to such class 3 institutional dispenser license. Records of distribution and administration of such bulk stocks of controlled substances shall be kept as provided in section 80.48(a) of this Part.

#### **80.49 - Records and reports of institutional dispensers, limited**

(a) All nursing homes, convalescent homes, health-related facilities, homes for the aged and other facilities licensed and authorized by the department as institutional dispensers limited and authorized to possess and distribute controlled substances prescribed for individual patients in their care shall keep a record of all such drugs received in custody and dispensed to patients.

(b) A separate daily running record shall be kept of all prescribed controlled substances received, indicating the date, name and quantity of prescribed controlled substances, name of the prescriber, name of the patient, name of the pharmacy and the pharmacy prescription number of the prescription containing the controlled substance, for patients under their care.

(c) A separate record shall be maintained of the administration of prescribed controlled substances indicating the date and hour of administration, name and quantity of controlled substances, name of the prescriber, patient's name, signature of person administering and the balance of the controlled substances on hand after such administration.

(d) In an emergency situation, a controlled substance from a sealed emergency medication kit may be administered to a patient by an order of an authorized practitioner. An oral order for such controlled substance shall be immediately reduced to writing and a notation made of the condition which required the administration of the drug. Such oral order shall be signed by the practitioner within 48 hours.

(1) For purposes of this subdivision, emergency means that the immediate administration of the drug is necessary and that no alternative treatment is available.

(2) A separate record shall be maintained of the administration of controlled substances from an emergency medication kit. Such record shall indicate the date and hour of administration, name and quantity of controlled substances, name of the practitioner ordering the administration of the controlled substance, patient's name, signature of the person administering and the balance of the controlled substances in the emergency medication kit after such administration.

(3) The institutional dispenser limited shall notify the pharmacy furnishing controlled substances for the emergency medication kit within 24 hours of each time the emergency kit is unsealed, opened, or shows evidence of tampering.

**80.50 - Minimum security standards for institutional dispensers, institutional dispensers limited, treatment programs, license holders engaging in research, instructional activities and chemical analysis**

(a) Reserve or main stocks of controlled substances shall be securely kept as follows:

(1) Schedule I and II controlled substances shall be kept in one of the following secure storage areas:

(i) A GSA class 5 rated steel cabinet or equivalent safe approved by the Bureau of Narcotic Enforcement of the Department of Health. Any cabinet or safe weighing less than 750 pounds shall be bolted or cemented to the floor or wall in such a way that it cannot be removed. The door of the cabinet or safe shall contain a multiple position combination lock, a relocking device or the equivalent, and steel plate having a thickness of at least one-half inch.

(ii) A vault, constructed of substantial masonry and having a multiple position combination lock, a relocking device or the equivalent, and a door having a thickness of steel plate of at least one-half inch. For new construction, floor, walls and ceiling shall not be less than eight inches of reinforced concrete, but less may be accepted where there are compensating extra safeguards.

(2) Schedule III, IV and V controlled substances shall be stored in a securely locked cabinet of substantial construction.

(b) Working stocks of controlled substances of a registered pharmacy may be dispersed throughout the stocks of noncontrolled substances in such a manner as to obstruct theft or diversion provided the conditions of section 80.6 of this Part are met and the pharmacy is locked when not in operation. If not dispersed, controlled substances in Schedules II, III and IV shall be kept in a stationary, securely locked cabinet of substantial construction.

(c) Working stocks of controlled substances for institutional dispensers without a registered pharmacy, treatment programs, license holders engaging in research, instructional activities, and chemical analysis shall be securely kept as follows:

(1) Schedule I, II, III and IV controlled substances shall be kept in stationary, locked double cabinets. Both cabinets, inner and outer, shall have key-locked doors with separate keys; spring locks or combination dial locks are not acceptable. For new construction, cabinets shall be made of steel or other approved metal.

(2) Schedule V controlled substances shall be stored in a stationary, securely locked cabinet of substantial construction.

(3) Limited supplies of controlled substances for use in emergency situations may be stocked in sealed emergency medication kits.

(d) Patient care units of institutional dispensers or institutional dispensers limited shall safeguard substances as follows:

(1) Controlled substances kept as floor stocks on patient care units for general patient use and quantities prescribed or ordered for a specific patient which would exceed a 72-hour supply shall be stored as specified in subdivision (c) of this section.

(2) Controlled substances prescribed or ordered for a specific patient in quantities which would not exceed a 72-hour supply may be stored with the patient's other medications at the patient care unit, provided that they are kept in a securely locked medication cart or other storage unit approved by the department.

(3) Medication carts. Schedule II controlled substances may not be stocked in medication carts.

(i) Medication carts may be utilized to stock Schedule III, IV and V controlled substances as provided in paragraph (2) of this subdivision, provided they are equipped with the following:

(a) double-keyed locks;

(b) when not in use, anchored to a floor or wall device or maintained in another secure location;

(c) locked drawer system; and

(d) independent locking device.

(ii) Access to medication carts shall be limited to an identified individual at all times. Such carts are to be used only in conjunction with a pharmacy-maintained patient profile summary.

(4) Records. The following records shall be maintained of controlled substances stocked, dispensed or administered in medication carts:

(i) An order, signed by a person authorized to prescribe under the provisions of this Part, specifying the controlled substances medication for an indicated person or animal.

(ii) A separate record, at the main point of supply for controlled substances, showing the type and strength of each drug, in the form of a running inventory indicating the dates and amounts of such drugs compounded by them or received from other persons and their distribution or use.

(iii) A record of authorized requisitions for such drugs and the distribution to substations or wards should be maintained. Such records shall show delivery to substation or ward by the authorized signature of dispensing personnel. (iv) A record in the patient's chart indicating administration of the controlled substance, including the name of the administering attendant and the date and hour of administration.

(e) Except as provided in paragraph (1) of this subdivision, institutional dispensers limited may only possess controlled substances prescribed for individual patient use, pursuant to prescriptions filled in a registered pharmacy. These controlled substances shall be safeguarded as provided in subdivision (d) of this section.

(1) Except for adult care facilities subject to the provisions of 18 NYCRR Parts 487, 488 and 490, institutional dispensers limited may possess limited supplies of controlled substances in sealed emergency medication kits for use as provided in section 80.49(d) of this Part. Each kit may contain up to a 24-hour supply of a maximum of 10 different controlled substances in unit dose packaging, no more than three of which may be in an injectable form. Each kit shall be secured in a stationary, double-locked system or other secure method approved by the department.

(f) Only controlled substances shall be stored within the storage facilities described in this section, except in an automated dispensing system and as noted in subdivision (b) and paragraph (d)(2) of this section.

### **80.51 - Surrender and disposal of controlled substances**

(a) As described in this section, the destruction of controlled substances shall mean that the substances have been rendered totally unrecoverable and beyond reclamation.

(b) Single-unit doses or partial doses remaining after the administration or attempted administration of a portion of a liquid or solid unit dose of a controlled substance may be destroyed on the premises of an institutional dispenser by a pharmacist or nurse provided that:

(1) a notation is made on the administration record sheet; and

(2) the destruction is witnessed by a second pharmacist or nurse or other responsible person designated by the administrator.

(c) A person holding a Federal registration number, or who is licensed by the Department under Article 33 of the Public Health Law, or a person with lawful temporary custody possessing controlled substances, which are undesired, deteriorated, obsolete, or for any reason no longer needed shall:

(1) return such controlled substances to the licensed distributor or manufacturer from whom the controlled substances were purchased provided, that a manufacturer or distributor is required to accept only those full packages of controlled substances still in the sealed containers but may accept partial containers if it wishes to do so; or

(2) surrender such controlled substances to such other person approved by the Bureau of Narcotic Enforcement to receive controlled substances for destruction; or

(3) destroy the controlled substances in the presence of a witness who shall be a New York State licensed practitioner, pharmacist or nurse, provided that:

(i) the person shall request from the Department permission to destroy controlled substances at least two weeks prior to the intended destruction. Such requests must be made in writing and must include the following information:

(a) an inventory of controlled substances to be destroyed;

(b) the specific method of destruction to be employed;

(c) the date, time and location of intended destruction;

(d) the identity of at least two persons to conduct and witness the destruction. Such witnesses shall be New York State-licensed practitioners, pharmacists or nurses; and

- (e) the reason for the destruction;
- (ii) the Department shall determine whether or not to grant approval for the destruction by considering factors that include, but are not limited to:
- (a) the record of compliance with Article 33 of the Public Health Law by the licensee, its employees, and the persons designated to witness the destruction;
  - (b) the type, nature and schedule of the drugs proposed for destruction, including the potential for diversion of such drugs during the destruction process;
  - (c) the licensee's pattern and frequency of requests for approval to destroy and of surrenders of controlled substances to the Department;
- (iii) a person may destroy controlled substances only after receiving the written approval of the Department which will include specific protocols for and methods of destruction.
- (iv) if the Department does not grant approval for the person to destroy controlled substances, the person shall surrender the controlled substances to the Department by following the requirements in paragraph (4) of this subdivision; or
- (4) surrender the controlled substances to the New York State Department of Health, Bureau of Narcotic Enforcement in the following manner:
- (i) the person shall request a surrender date from the bureau on which to surrender the controlled substances to the bureau. Such a request shall be made on forms provided by the bureau and must include the following information:
    - (a) an inventory of all controlled substances to be surrendered;
    - (b) the identity of at least two persons who conducted the inventory of the controlled substances to be surrendered. Such persons shall be New York State licensed practitioners, pharmacists or nurses;
    - (c) the reason for the surrender of each controlled substance; and
    - (d) the proposed date of surrender and an alternative date.
  - (ii) a person may surrender controlled substances only after receiving a surrender date in writing from the bureau. The controlled substances must be shipped to the bureau no later than five days from the date the bureau has set as the surrender date. The bureau may set a date different than the date requested by the applicant.
  - (iii) all controlled substances to be surrendered to the bureau must be packaged in the following manner:
    - (a) all solid dosage forms of controlled substances must be packaged by placing each controlled substance in separate, individual, paper packaging only. The package must be properly labeled with the name of the licensee, DEA registration number and the name, strength and quantity of the controlled substance;
    - (b) all liquids, including injectable preparations and prefilled syringes, shall be emptied into individual plastic containers. A label shall be affixed to the container with

the name of the licensee, DEA registration number and the name, strength and quantity of the controlled substance. Glass containers are prohibited;

(c) no needles or syringes shall be surrendered to the Department for destruction; or

(5) surrender the controlled substances to the federal Drug Enforcement Administration, or its successor agency.

(d) Recordkeeping requirements.

(1) Any person disposing of a controlled substance by returning it to the distributor or to the manufacturer, by destroying the controlled substance in the presence of a witness, or by surrendering it to the Department, must maintain a written record containing:

(i) date of return or destruction;

(ii) name, form, quantity of the substance returned or destroyed;

(iii) name, address, registry number of the person making the return;

(iv) name, address, registry number of the supplier or manufacturer to whom the substances are returned or the name and license number of the persons performing and witnessing the destruction.

(2) Any distributor or manufacturer receiving such controlled substances shall keep a record of those controlled substances received and include:

(i) the name, address, registry number of the person making the return;

(ii) the name, form and quantity of the substance returned; and

(iii) the date the substance was received.

(3) Any person surrendering controlled substances to the Drug Enforcement Administration shall maintain records of such surrenders as may be required by that agency.

(4) Any record required to be kept under this section shall be kept for a period of five years.

(e) Persons licensed under Article 33 of the Public Health Law as manufacturers or distributors may destroy controlled substances on their premises providing that federal Drug Enforcement Administration approval is obtained and a copy of such approval is filed with the Department within 30 days of the receipt of such approval.

## 18 NYCRR

### PART 357 CONFIDENTIAL NATURE OF RECORDS

(Statutory authority: Social Services Law, Sections 20, 34)

357.1 Nature of information to be safeguarded

357.2 Prohibition against disclosure of information

357.3 Basis for disclosure of information

357.4 Prohibition against improper use of lists of applicants and recipients

357.5 Procedures for safeguarding information maintained by the New York State Department of Social Services, local social services districts and other authorized agencies

357.6 Confidentiality policy and procedures manual

#### **357.1 Nature of information to be safeguarded.**

(a) Information to be safeguarded includes names and addresses of applicants, recipients, and their relatives, including lists thereof; information contained in applications and correspondence; reports of investigations; reports of medical examination, diagnostic tests and treatment, 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; resource information; financial statements; and record of agency evaluation of such information. This applies to all information secured by the agency whether or not it is contained in the written record.

(b) For purposes of this Part:

(1) "AIDS" means acquired immune deficiency syndrome, as may be defined from time to time by the Centers for Disease Control of the United States Public Health Service.

(2) "HIV infection" means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS.

(3) "HIV-related illness" means any illness that may result from or may be associated with HIV infection.

(4) HIV-related test means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or to indicate the presence of AIDS.

#### **357.2 Prohibition against disclosure of information.**

(a) Officers and employees of social services districts shall not reveal information obtained in the course of administering public assistance for purposes other than those directly connected with the administration of public assistance, except for the name, address and the amount received by or expended for a recipient of public assistance when the appropriating body or social services official has authorized their disclosure to an agency or person deemed entitled to it pursuant to section 136 of the Social Services Law.

(b) Any release of information pursuant to this section which would reveal that a person has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, is subject to the provisions of section 2782 of the Public Health Law. In accordance with such section, confidential HIV related information relating to a recipient of a health or social service as defined in section 2780 of the

Public Health Law, may be disclosed to authorized employees of the department or of social services districts when reasonably necessary for such employees to supervise, monitor, administer or provide such service and such employees would, in the ordinary course of business, have access to records relating to the care of, treatment of or provision of a health or social service to such recipient.

(c) Each social services official shall designate the person, or persons, within the agency with authority to disclose information.

### **357.3 Basis for disclosure of information.**

(a) Safeguards in disclosing information. Information shall be released to another agency or person only when the public welfare official providing such data is assured that:

(1) the confidential character of the information will be maintained;

(2) the information will be used for the purposes for which it is made available, such purposes to be reasonably related to the purposes of the public welfare program and the function of the inquiring agency; and

(3) the information will not be used for commercial or political purposes.

(b) Disclosure of medical information. (1) Upon the transfer of a foster child to the care of another authorized agency, the former agency must provide to the receiving agency the child's comprehensive health history, both physical and mental, to the extent it is available.

(2) To the extent they are available, the comprehensive health history of the child and of his or her biological parents and the health care needs of the child must be provided by an authorized agency to foster parents at the time of the child's placement in foster care. In all cases, information identifying the biological parents must be removed from the comprehensive medical history.

(3) To the extent it is available, the comprehensive health history, both physical and mental, of a child legally freed for adoption and of his or her biological parents must be provided by an authorized agency to the child's prospective adoptive parent(s). Prospective adoptive parent means an individual who meets criteria as defined in section 421.16 of this Title and who has indicated an interest in adopting a particular child, and for whom the authorized agency has begun the placement agreement process in accordance with section 421.18 of this Title. In the case of finalized adoptions, such information must be provided upon request to the child's adoptive parents. In all cases, information identifying the biological parents must be removed from the comprehensive health history.

(4) To the extent it is available, the comprehensive health history, both physical and mental, of a child in foster care and of his or her biological parents must be provided by an authorized agency to such child when discharged to his or her own care.

(5) To the extent it is available, the comprehensive health history of a child in foster care must be provided to the child's parents or guardian when the child is discharged to their 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 as defined in section 360-8.1(a)(8) of this Title and in article 27-F of the Public Health Law. The term confidential HIV-related information is defined in section 360-8.1(a)(5) of this Title and in article 27-F of the Public Health Law.

(6) To the extent it is available, the comprehensive health history, both physical and mental, of any adopted former foster child and of his or her biological parents must be provided by an authorized agency to the adopted former foster child upon request. In all cases, information identifying the biological parents must be removed from the comprehensive health history.

(7) For the purposes of this subdivision, the comprehensive health history must include, but is not limited to, conditions or diseases believed to be hereditary, where known; drugs or medication taken during pregnancy by the child's biological mother, where known; immunizations received by the child while in foster care and prior to placement in care, where known; medications dispensed to the child while in care and prior to placement in care, where known; allergies the child is known to have exhibited while in care and prior to placement in care, where known; diagnostic tests, including developmental or psychological tests and evaluations given to the child while in care and prior to placement in care, where known, and their results, laboratory tests for HIV, where known, and their results; and any follow-up treatment provided to the child prior to placement in care, where known, or provided to the child while in care, or still needed by the child.

(c) Disclosure to applicant, recipient, or person acting in his behalf. (1) The case record shall be available for examination at any reasonable time by the applicant or recipient or his authorized representative upon reasonable notice to the local district. The only exceptions to access are:

(i) those materials to which access is governed by separate statutes, such as child welfare, foster care, adoption or child abuse or neglect or any records maintained for the purposes of the Child Care Review Service;

(ii) those materials being maintained separate from public assistance files for purposes of criminal prosecution and referral to the district attorney's office; and

(iii) the county attorney or welfare attorney's files.

(2) Information may be released to a person, a public official, or another social agency from whom the applicant or recipient has requested a particular service when it may properly be assumed that the client has requested the inquirer to act in his behalf and when such information is related to the particular service requested.

(d) Disclosure to relatives and other legally responsible persons.

(1) To the extent available and upon request, an authorized agency must provide a relative or other legally responsible person with whom a child is placed, or to whom a child is discharged or released, by the family court pursuant to section 1017 or 1054 of the Family Court Act, but who is not a foster parent for the child, with the same background information regarding the child as is provided to a foster parent with whom a child is placed. Such information, as available, must include the child's medical history and any other information which is provided to a foster parent as necessary for the child's health, safety and welfare pursuant to this section, section 443.2 of this Title, and any other applicable regulations of the Office of Children and Family Services. However, if the child's medical history includes confidential HIV-related information, such information must not be provided to the relative or other legally responsible person without a written release from:

(i) the child, if the child has capacity to consent as defined in section 360-8.1(a)(8) of this Title and in article 27-F of the Public Health Law; or

(ii) a person authorized to consent to health care for the child, if the child lacks capacity to consent.

(2) A social services district is required, under section 132 of the Social Services Law, to investigate the ability and willingness of relatives, and the liability of legally responsible relatives, to contribute to the support of an applicant for or recipient of public assistance or care. In regard to these investigations, such a relative is a person considered entitled, under section 136 of the Social Services Law, to necessary and appropriate information regarding the applicant or recipient. Information concerning the applicant's or recipient's needs and basic circumstances may be disclosed to such a relative to the extent necessary to discuss contributions of support from that relative. However, confidential HIV-related information may not be disclosed to such a relative without a written release from:

(i) the applicant or recipient, if the applicant or recipient has capacity to consent as defined in section 360-8.1(a)(8) of this Title and in article 27-F of the Public Health Law; or

(ii) from a person authorized to consent to health care for the applicant or recipient, if the applicant or recipient lacks capacity to consent.

(3) The social services district or other authorized agency must, in writing, inform the relative or other legally responsible person receiving information under this subdivision, of the confidential nature of the information and of any restrictions against redisclosure of such information. In the case of confidential HIV-related information, the warning statement against redisclosure set forth in section 360-8.1(h) of this Title and in article 27-F of the Public Health Law must be provided to the person receiving confidential HIV-related information.

(4) The term confidential HIV-related information is defined in section 360.8-1(a)(5) of this Title and in article 27-F of the Public Health Law. The conditions for the written release authorizing disclosure of such information are set forth in section 360-8.1(g) of this Title and in article 27-F of the Public Health Law.

(e) Disclosure to Federal, State or local official. (1) Information may be disclosed to any properly constituted authority. This includes a legislative body or committee upon proper legislative order, an administrative board charged with investigating or appraising the operation of public welfare, law enforcement officers, grand juries, probation and parole officers, government auditors, and members of public welfare boards, as well as the administrative staff of public welfare agencies.

(2) Information may be released to a selective service board when such information is necessary in order that the board may arrive at a valid and consistent decision regarding dependency. (3) A social services official must disclose to a federal, state or local law enforcement officer, upon request of the officer, the current address of any recipient of family assistance, or safety net assistance if the duties of the officer include the location or apprehension of the recipient and the officer furnishes the social services official with the name of the recipient and notifies the agency that such recipient is fleeing to avoid prosecution, custody or confinement after conviction, under the laws of the place from which the recipient is fleeing for a crime or an attempt to commit a crime which is a felony under the laws of the place from which the recipient is fleeing, or which, in the case of the state of New Jersey, is a high misdemeanor under the laws of that state, or is violating a condition of probation or parole imposed under a federal or state law or has information that is necessary for the officer to conduct his or her official duties. In a request for disclosure pursuant to this paragraph, such law enforcement officer must endeavor to include identifying information to help ensure that the social services official discloses only the address of the person sought and not the address of a person with the same or similar name.

(4) Nothing in this Part precludes a social services official from reporting to an appropriate agency or official, including law enforcement agencies or officials, known or suspected instances of physical or mental injury, sexual abuse or exploitation, sexual contact with a minor or negligent treatment or

maltreatment of a child of which the social services official becomes aware of in the administration of public assistance and care.

(5) Nothing in this Part precludes a social services official from communicating with the federal immigration and naturalization service regarding the immigration status of any individual.

(f) Disclosure upon subpoena by court. (1) When a public assistance record is subpoenaed by court, the public welfare agency shall immediately consult its legal counsel before producing any record or revealing any information or giving any testimony.

(2) When the subpoena is for a purpose directly related to the administration of public assistance or protection of the child, the agency before complying with the subpoena shall endeavor to get in touch with the client whose record is involved or his attorney and secure permission to reveal the contents of the record which relate to the administration of public assistance.

(3) In the event that the subpoena is for a purpose not directly related to the administration of public assistance or the protection of a child, the agency shall plead, in support of its request to withhold information, that the Social Security Act, the Social Services Law and the regulations of the State Department of Social Services prohibit disclosure of confidential information contained in records and files, including names of clients. The agency will be governed by the final order of the court after this plea is made.

(g) Disclosure to bona fide news disseminating firm. The written assurance required by section 136 of the Social Services Law that the names and addresses of applicants and recipients of assistance shall not be published, shall be obtained by the public welfare official before allowing examination of records of disbursements by that bona fide news disseminating firm.

(h) Disclosure of confidential HIV related information.

(1) Notwithstanding any other provision of any law or regulation, confidential HIV related information concerning persons claiming disability benefits under the provisions of titles II and XVI of the Social Security Act may be disclosed to persons employed by or acting on behalf of the department's office of disability determinations engaged in the conduct of processing such claims on the basis of a general medical release in the form approved by the Social Security Administration of the United States Department of Health and Human Services. The employees and agents of the office of disability determinations, including providers of clinical laboratory services, consultative medical examinations or claimant-related medical information, to the extent they have acted in accordance with department procedures and instructions, will be held harmless and indemnified by the department for any liability for the disclosure or redisclosure of any HIV related information when such information is solicited by or provided to the office of disability determination.

(2) All medical information, including confidential HIV related information, solicited by or provided to the office of disability determinations for the purpose of determining a person's disability will be treated as confidential and this information must not be disclosed except as prescribed by the regulations of the Secretary of the United States Department of Health and Human Services.

(3) The term confidential HIV related information is defined in section 360-8.1 of this Title.

\* (i) Disclosure of domestic violence related information.

(1) Information with respect to victims of domestic violence collected as a result of procedures for domestic violence screening, assessment, referrals and waivers pursuant to Part 351 of this Title shall not be released to any outside party or parties or other government agencies unless the information is required to be disclosed by law, or unless authorized in writing by the public assistance applicant or recipient.

(2) Employees of the Office, social services district or any agency providing domestic violence liaison services, consistent with applicable statute and regulation, may have access to client identifiable information maintained by a domestic violence liaison or by the welfare management system only when the employees' specific job responsibilities cannot be accomplished without access to client identifiable information.

(3) Each social service district and agency providing domestic violence liaison services, with access to the welfare management system, must develop and implement policies and practices to ensure the maintenance of confidential individual information. \* NB Effective until 98/08/06

(j) *Disclosure of education information.* To the extent available, an authorized agency must provide a copy of a foster child's education record at no cost to the child when such foster child is discharged to his or her own care. For the purposes of this subdivision, the education record of a foster child includes the names and addresses of the child's educational providers; the child's grade level performance; assurances that the child's placement in foster care took into account proximity to the school in which the child was enrolled at the time of placement; and any other relevant education information concerning the child.

**357.4 Prohibition against improper use of lists of applicants and recipients.** (Additional statutory authority: Social Services Law, Sections 136, 258, 320)

All material sent to applicants and recipients of public assistance, including material enclosed in envelopes containing checks, must be directly related to the administration of the public assistance programs and shall not have political implications.

**357.5 Procedures for safeguarding information maintained by the New York State Department of Social Services, local social services districts and other authorized agencies.**

(a) Records containing individually identifiable information shall be marked "confidential" and kept in locked files or in rooms that are locked when the records are not in use.

(b) When in use, records shall be maintained in such a manner as to prevent exposure of individual identifiable information to anyone other than the authorized party directly utilizing the case record.

(c) No records shall be taken from the place of business without prior authorization by appropriate supervisory staff of the New York State Department of Social Services, the local social services district or other authorized agency.

(d) No records shall be taken home by agency staff except upon prior authorization by appropriate supervisory staff in order to perform a function which requires the possession of the records outside of the agency and where return of the records to the agency at the close of business would result in an undue burden to the staff. In those cases where records are taken home by staff, the records are to be maintained in a secure location and are not to be disclosed to anyone other than those expressly authorized by statute or regulation. The records are to be returned to the agency by staff on the following business day.

(e) Records shall be transmitted from one location to another in sealed envelopes stamped "confidential," and a receipt shall be obtained documenting delivery of said records.

(f) Interviews with clients shall be conducted at a location and in a manner which maximizes privacy.

(g) Employees of the New York State Department of Social Services, the local social services district or the other authorized agency, consistent with applicable statute and regulation, shall have access to individual identifiable information only where the employee's specific job responsibilities cannot be accomplished without access to individual identifiable information.

**357.6 Confidentiality policy and procedures manual.**

The New York State Department of Social Services, local social services districts, and other authorized agencies shall disseminate to staff a policy and procedures manual establishing and describing:

- (a) responsibilities of staff to safeguard information pursuant to statute, regulation and policy;
- (b) procedures for properly informing clients of records collection, access, utilization and dissemination;
- (c) policies and practices relating to the safeguarding of confidential information by the agency;
- (d) procedures relating to employee access to information; and
- (e) disciplinary actions for violations of confidentiality statutes, regulations and policies.



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### 428.3 Uniform case record requirements.

(a) All social services districts must establish and maintain a single uniform case record for each family for whom a case record is required pursuant to section 428.1 of this Part.

(b) (1) Each uniform case record must include, but need not be limited to the following items in the form and manner prescribed by OCFS:

(i) a common application form;

(ii) family assessments and service plans at regularly scheduled intervals in accordance with subdivision (f) of this section;

(iii) plan amendments, as required by section 428.7 of this Part completed for each status change;

(iv) all forms for the child care review service pursuant to sections 406.4 and 465.1 of this Title, for as long as that system remains the official system of record of OCFS;

(v) face sheet;

(vi) progress notes in the form and manner prescribed by OCFS;

(vii) all official documents and records of any judicial or administrative proceedings relating to the district's contact with a child and/or a family, including but not limited to records of petitions, permanency hearing reports and notices, court orders, probation reports, voluntary instruments or agreements, fair hearings, administrative reviews, and the results of any examinations or evaluations ordered by a court;

(viii) all correspondence between the family, the district and/or purchase of service agencies;

(ix) information received from private or public purchase of service agencies, concerning casework contacts with a child and/or his or her family receiving family and children services; and

(x) all documentation relating to the establishment of categorical eligibility for any funding source for which the child or family may be eligible.

(2) For foster care placement cases, additional information and documents must also include:

(i) data and official documents relating to the identification and/or history of a child and/or his/her family, including but not limited to copies of birth certificates, documentation of religion, documentation of the child's immigration status, and any consent forms and/or religious preference forms signed by the parent or guardian;

(ii) all reports of medical or clinical examinations or consultations, including medical examinations and laboratory tests, psychiatric or psychological examinations or consultations (either court-ordered or voluntary), dental examinations; and medical consent forms signed by the parent or guardian, by the commissioner of the social services district, or by the child if the child has the capacity to consent, as applicable, regarding medical treatment for any child in foster care

placement, including documentation that the child has been assessed for risk factors related to HIV infection in accordance with section 441.22(b) of this Title, and, if one or more risk factors have been identified, a description of the procedures that were followed to arrange for appropriate HIV-related testing including obtaining the necessary written informed consent for such testing;

(iii) educational and/or vocational training reports or evaluations indicating the educational goals and needs of each foster child, including school reports and Committee on Special Education evaluations and/or recommendations; and

(iv) if the child has been placed in foster care outside of the state, a report prepared every six months by a caseworker employed by either the authorized agency with case management and/or case planning responsibility for the child, the state in which the placement home or facility is located, or a private agency under contract with either the authorized agency or other state, documenting the caseworker's visit(s) with the child at his or her placement home or facility within the six-month period.

(c) A single family assessment and service plan must be completed as specified in section 428.6 of this Part, for all family members at the intervals described in subdivision (f) of this section. The assessment and service plan must include a description of the collaborative efforts of the case planner and all case workers assigned to the case.

(d) Each family assessment and service plan, must document the involvement of the parent(s) or guardian and, where appropriate, child(ren) 10 years or older, including children in foster care and their siblings or half-siblings and children placed by a court in the direct custody of a relative or other suitable person pursuant to article 10 of the Family Court Act, in the development of the plan, or must document efforts to involve them in the development of the plan. Such efforts must include, but are not limited to:

(1) encouraging parent(s) or guardian and the children to participate in the development and review of the plan, and attempting to obtain the parent(s)' or guardian's signatures documenting their review of the plan; and

(2) where parent(s) or guardian and/or children are not able to participate in the development of the plan and arrangements cannot be made to allow participation, conveying the contents of the service plan and any recommendations to them, and attempting to obtain the parent(s)' or guardian's comments and signatures documenting their review of the plan.

(e) For foster care cases and for children placed by a court in the direct custody of a relative or other suitable person pursuant to article 10 of the Family Court Act, the service plan review requirements of section 428.9 of this Part also apply.

(f) Case process flow.

(1) Social services districts must initiate a uniform case record for a family on the case initiation date as defined in section 428.2(a) of this Part.

(2) On the case initiation date, the following must be completed and become part of the uniform case record:

(i) a common application form; and

(ii) face sheet or equivalent in accordance with section 428.4 of this Part.

- (3) Documentation of casework activity and contacts in progress notes must begin on the case initiation date or, for cases where a report has been accepted by the Statewide central register, casework activity must be recorded in progress notes from the date of receipt of the report of suspected abuse or maltreatment.
- (4) Except for open indicated child abuse and maltreatment cases, an initial family assessment and service plan must be completed by the social services district or by a provider agency providing services pursuant to a purchase of service agreement, and must be approved by the case manager within 30 days from the case initiation date. For open indicated child abuse and maltreatment cases, an initial family assessment and service plan must be completed by the social services district or the provider agency providing services pursuant to a purchase of service agreement, and approved by the case manager within seven days of the date that a report to the Statewide central register is determined to be indicated.
- (5) A comprehensive family assessment and service plan must be completed by the social services district or by a provider agency providing services pursuant to a purchase of service agreement and must be approved by the case manager within 90 days from the case initiation date.
- (6) The first family reassessment and service plan must be completed by the social services district or by the provider agency providing services pursuant to a purchase of service agreement, and must be approved by the case manager no later than 210 days from the case initiation date. All subsequent family reassessment and service plan reviews must be completed by the social services district or by the provider agency providing services pursuant to a purchase of service agreement, and must be approved by the case manager six months from the due date of the previous reassessment and every six months thereafter.
- (7) A plan amendment must be completed by the social services district or by the provider agency providing services pursuant to a purchase of service agreement, and must be approved by the case manager for the case, in accordance with the requirements of section 428.7 of this Part, whenever a significant change occurs in the status of the case.
- (g) Each initial family assessment, comprehensive family assessment and family reassessment developed in accordance with this Part must contain, as applicable: a written consideration of whether it is safe for the child to remain in his or her home; or whether it is safe for the child to remain in his or her current foster care placement, and whether it is safe to discharge the child from foster care.
- (h) The name or other information identifying the reporter and/or the source of a report of suspected child abuse or maltreatment, as well as the agency, institution, organization, and/or program with which such person(s) is associated must only be recorded or documented in progress notes and such documentation must be recorded in the manner specified by OCFS.



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### 431.7 Standards for access to and disclosure of confidential HIV related information.

- (a) Staff of an authorized agency as defined by paragraphs (a) and (b) of section 371(10) of the Social Services Law must comply with the following standards relating to access to and disclosure of confidential HIV related information.
- (1) Each authorized agency is responsible for formulating a written management plan to ensure that required safeguards are implemented and enforced to restrict the disclosure of confidential HIV related information concerning children in its care. This management plan must be available for review by the Department and must include:
    - (i) procedures consistent with section 2782.6 of the Public Health Law to ensure that documents containing confidential HIV related information are accessible only to an authorized employee or agent of the authorized agency when disclosure is reasonably necessary for the supervision, monitoring, administration or provision of services provided by such agencies. For the purpose of this section, an authorized employee or agent means an employee or agent who, in the ordinary course of business of the authorized agency, has access to records relating to the care of, treatment of, or provision of services to the person; and
    - (ii) measures to ensure that confidential HIV related information stored electronically is protected from access by unauthorized persons; and
    - (iii) a plan for training agency staff regarding HIV infection, confidentiality of HIV related information, and protection of persons at significant risk in accordance with subdivision (c) of this section.
  - (2) Such authorized employees or agents must be provided with a written statement warning of penalties for unauthorized disclosure 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 of both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure."
  - (3) Redisclosure of confidential HIV related information by an authorized agency is not permitted except in a manner consistent with article 27-F of the Public Health Law, section 373-a of the Social Services Law and section 357.3(b) of this Title.
  - (4) Confidential HIV related information included in the child's health history must be provided to:
    - (i) another authorized agency to whom the care of the child is transferred;
    - (ii) the foster parents who have responsibility for the child's care;

- (iii) the prospective adoptive parents as defined in section 421.1 of this Title or adoptive parents of the child;
  - (iv) the biological parents when the child is discharged to such parents and such disclosure is authorized by section 2782 of the Public Health Law;
  - (v) a child discharged to his or her own care.
- (5) Confidential HIV related information is defined in section 360-8.1 of this Title.
- (b) (1) Foster parents may redisclose confidential HIV-related information concerning a foster child boarded out or placed with such parents to persons or entities other than those set forth in Article 27-F of the Public Health Law only:
- (i) when redisclosure is for the purpose of providing care, treatment or supervision of the foster child; or
  - (ii) upon specific written authorization signed by the commissioner of the social services district or such commissioner's designated representative in accordance with Article 27-F of the Public Health Law. Such authorization must be maintained in the child's uniform case record.
- (2) Any disclosure of confidential HIV-related information by a foster parent, except as authorized by Article 27-F of the Public Health Law, must be accompanied by a statement in writing which includes the following or substantially similar language:
- "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 the 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."
- (c) Training of Staff. Each authorized responsible for the care of HIV infected children, and for maintaining the confidentiality of records for such children, must provide initial training within 90 days of promulgation of these regulations, and thereafter at least annually, to all staff persons authorized to have access to any files and records, written or electronic, containing information on HIV infected children. As new staff with such access are added to agency personnel, initial training must be provided within 45 days of employment. Such training must include, but is not limited to:
- (1) a review of State law and department regulations related to confidentiality of HIV information, including, but not limited to:
    - (i) the necessity for written authorization for redisclosure on a case by case assessment;
    - (ii) the list of specific persons to whom HIV related information in the child's health history must be provided in accordance with Social Services Law 373-a and Section 357.3(b) of this Title; and

- (iii) the provision of the required warning statement of penalties for redisclosure in accordance with section 405.3(g)(16) of this Title.
- (2) a review of the agency's written management plan for maintaining security of records;
- (3) information on factors which constitute significant risk of contracting or transmitting HIV infection as defined by the State Department of Health regulations 10 NYCRR Part 63.9. Such factors include the presence of significant risk body substances, principally blood and semen, and the circumstances which result in transmission of such substances;
- (4) hygienic measure recommended for the protection of persons caring for an HIV infected child and for protection of HIV infected children from unnecessary exposure to additional infections. Such measures include:
  - (i) standard accepted practices for cleanliness and infection control;
  - (ii) the use of preventive barriers where indicated, specifically if the caretaker's skin has open wounds or abrasions, or if there is presence of blood; and
- (5) current research information concerning HIV infection which includes, but is not limited to, the evidence that HIV disease is not transmitted by casual or in ordinary home and family care of children.
- (d) Law Guardian. When requested by a law guardian, an authorized agency must disclose confidential HIV-related information concerning a foster child to the law guardian if the law guardian is appointed to represent the foster child pursuant to the Social Services Law or the Family Court Act and the information is for the purpose of representing the foster child. A law guardian appointed to represent a child may redisclose confidential HIV-related information only with the consent of the child if the child has capacity to consent. If the child lacks capacity to consent, the law guardian may redisclose confidential HIV-related information for the sole purpose of representing the child.

#### Revisions

(7/10/91 subd. (b) is repealed, new subd. (b) added; new subd. (d) added).



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### 441.15 Special services.

Psychiatric, psychological and other essential services shall be made available appropriate to the needs of the children in care.

### 441.22 Health and medical services.

- (a) Each authorized agency is responsible for providing comprehensive medical and health services for every foster child in its care.
- (b) Assessment and testing of children in foster care for HIV infection. The terms AIDS, HIV infection, HIV-related illness and HIV-related test are defined in section 360-8.1 of this Title.
  - (1) Assessment for risk factors for HIV infection. Each child in foster care must be assessed for risk factors related to HIV infection and to determine whether the child has the capacity to consent to HIV-related testing. 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 concerning the service, treatment, procedure or disclosure.
  - (2) Timing of the initial assessments.
    - (i) Each child entering foster care on or after September 1, 1995, must be assessed within five business days of entry into care to determine, based on the child's developmental stage and cognitive abilities, whether it is possible that the child may have the capacity to consent to HIV-related testing.
      - (a) If it is determined that there is no possibility that the child has the capacity to consent, then within five business days of the child's entry into care the authorized agency also must complete an initial assessment of the child's risk for HIV infection based on the risk factors set forth in this subdivision.
      - (b) If it is determined that there may be a possibility that the child has capacity to consent, then within 30 business days of the child's entry into care, the authorized agency must: initiate discussions and counseling with the child based on the child's developmental stage and cognitive abilities regarding the behaviors that create a risk for HIV infection and the importance of reducing and preventing such behaviors; complete an assessment of the child's risk for HIV infection using the risk factors set forth in this subdivision; and, determine whether the child has the capacity to consent to HIV-related testing.
    - (ii) Each child who entered foster care prior to September 1, 1995, must be assessed, at least 60 business days prior to the next periodic medical examination required for the child in accordance with the schedule

provided in subdivision (f) of this section or at least 60 business days prior to the child's next required service plan review date, whichever occurs sooner, to determine, based on the child's developmental stage and cognitive abilities, whether it is possible that the child may have the capacity to consent to HIV-related testing.

- (a) If it is determined that there is no possibility that the child has the capacity to consent, the authorized agency must complete an initial assessment of the child's risk for HIV infection based on the risk factors set forth in this subdivision at least 30 days before the child's next periodic medical examination or the child's next service plan review date, as applicable.
  - (b) If it is determined that there may be a possibility that the child has capacity to consent, the authorized agency must initiate discussions and counseling with the child based on the child's developmental stage and cognitive abilities regarding the behaviors that create a risk for HIV infection and the importance of reducing and preventing such behaviors, complete an initial assessment of the child's risk for HIV infection using the risk factors set forth in this subdivision, and determine whether the child has capacity to consent to HIV-related testing at least 30 days before the child's next periodic medical examination or the child's next service plan review date, as applicable.
- (3) Assessment standards and risk factors related to HIV infection. The assessments of a child's capacity to consent and of a child's risk for HIV infection must be made by a medical provider or by designated agency staff with basic information and training regarding HIV and AIDS, knowledge of the risk factors associated with HIV infection, the HIV-related testing available and the confidentiality provisions regarding HIV-related information. The assessment of a child's risk for HIV infection must be appropriate for the age and developmental stage of the child and must include a review of the medical and psychosocial history available at the time to determine whether one or more of the following risk factors related to HIV infection exists:
- (i) Risk factors in the medical and psychosocial history of the family related to an infant or young child and associated with direct perinatal transmission of HIV infection at birth include:
    - (a) that this child had a positive drug toxicology or symptoms of drug withdrawal at birth;
    - (b) that this child had a positive test for syphilis at birth;
    - (c) that a sibling of this child has a diagnosis of HIV infection, initially tested positive for HIV infection but later seroreverted to negative, or died due to an HIV-related illness or AIDS;

- (d) that this child has symptoms consistent with HIV infection; or
  - (e) that this child was abandoned at birth and no risk history is available.
- (ii) Risk factors in the medical and psychosocial history of the family related to the child's mother or father, or a sexual partner of the child's mother or father. These risk factors are relevant generally to an infant or young child if they occurred before the child was born and placed the child at risk of HIV infection through perinatal transmission at birth. These risk factors include:
- (a) that the individual has a diagnosis of HIV infection, or symptoms consistent with HIV infection, or death due to HIV-related illness or AIDS;
  - (b) that the individual has or had a male sexual partner who has had sex with another man;
  - (c) that the individual has a history of sexually transmitted diseases, such as syphilis, gonorrhea, hepatitis B, or genital herpes;
  - (d) that the individual is known or reported to have had multiple sex partners or engaged in the exchange of sex for money, drugs, food, housing, or other things of value prior to the child's birth;
  - (e) that the individual is known or reported to inject illegal drugs or share needles, syringes or other equipment involved in drug use or body piercing;
  - (f) that the individual is known to use non-injection illegal drugs, such as crack cocaine;
  - (g) that the individual has a history of tuberculosis;
  - (h) that the individual had a transfusion of blood or blood products between January, 1978 and July, 1985 in the United States of America; or
  - (i) that the individual had a transfusion of blood or blood products in any other country at a time when the blood supply of that country was not screened for HIV infection.
- (iii) Risk factors related to the child and associated with the child's behavior or other means of direct transmission of HIV infection after the child's birth. The assessment of these risk factors may include discussions with the child, when appropriate for the age and developmental stage of the child, in addition to the required review of the medical and psychosocial history available at the time. These risk factors include:

- (a) that this child has symptoms consistent with HIV infection;
  - (b) that this child has been sexually abused;
  - (c) that this child has engaged in sexual activity;
  - (d) that this child has a history of sexually transmitted diseases, such as syphilis, gonorrhea, hepatitis B, or genital herpes;
  - (e) that this child is known or reported to have had multiple sex partners or engaged in the exchange of sex for money, drugs, food, housing, or other things of value;
  - (f) that this child is known or reported to inject illegal drugs or share needles, syringes or other equipment involved in drug use or body piercing;
  - (g) that this child is known or reported to use non-injection illegal drugs, such as crack cocaine;
  - (h) that this child has a history of tuberculosis;
  - (i) that this child had a transfusion of blood or blood products between January, 1978 and July, 1985 in the United States of America; or
  - (j) that this child had a transfusion of blood or blood products in any other country at a time when the blood supply of that country was not screened for HIV infection.
- (4) Procedures related to HIV-related testing. If a child is determined through the required assessment to have one or more risk factors for HIV infection, designated agency staff must initiate the following process necessary to obtain legal consent for HIV-related testing and to arrange for the HIV-related testing of the child based on the child's case circumstances:
- (i) A case involving a child identified as having one or more risk factors for HIV infection and determined to have the capacity to consent to an HIV-related test. In such case, the designated staff must:
    - (a) inform the child of the results of the assessment of risk factors for HIV infection and counsel the child regarding the benefits of being tested for HIV infection in order to receive medical care and services if an HIV infection is present;
    - (b) inform the child that arrangements may be made for agency-supervised confidential HIV-related testing and that anonymous testing is available as an alternative;
    - (c) provide information to the child of the requirements regarding the confidentiality of HIV-related information and the disclosures of

confidential HIV-related information to certain persons and entities required by article 27-F of the Public Health Law and section 373-a of the Social Services Law as set forth in paragraph (8) of this subdivision;

- (d) after providing the initial counseling and information to the child, ask the child whether he or she will agree to be referred for agency-supervised confidential HIV-related testing or anonymous testing; and
  - (e) if the child indicates that he or she will agree to be referred for agency-supervised confidential HIV-related testing, request that the child provide the authorized agency with written permission for such a referral and, within 30 business days of receiving such written permission arrange for the HIV-related testing of the child including obtaining the necessary pre-test counseling for the child, written informed consent of the child and post-test counseling for the child in accordance with article 27-F of the Public Health Law; or
  - (f) if the child indicates that he or she will agree to be referred for anonymous testing, offer to assist the child in obtaining access to an anonymous testing site; or
  - (g) if the child indicates that he or she will not agree to be referred for agency-supervised confidential HIV-related testing or anonymous testing, continue as part of the on-going casework contacts with the child to discuss the importance of HIV-related testing.
  - (h) Regardless of whether a child who has the capacity to consent agrees to be referred for HIV-related testing, designated agency staff must continue to provide on-going counseling to the child regarding the importance of preventing and reducing behaviors that create a risk of HIV infection.
- (ii) case involving a child identified as having one or more risk factors for HIV infection and determined to lack capacity to consent to HIV-related testing and whose parents have surrendered the guardianship and custody of the child pursuant to section 383-c or 384 of the Social Services Law or whose parental rights to the child have been terminated pursuant to section 384-b of the Social Services Law. In such case, the designated staff must contact the commissioner of the social services district in whose guardianship and custody the child is placed, or the commissioner's designated representative, who must provide the necessary written informed consent for the HIV-related testing of the child. Upon the issuance of such written informed consent by the commissioner or the commissioner's designated representative, the authorized agency must arrange for the HIV-related testing of the child.
- (iii) Any other case involving a child identified as having one or more risk factors for HIV infection and determined to lack capacity to consent to

HIV-related testing. In such case, designated staff in the authorized agency must:

- (a) inform immediately the parent or guardian of the child regarding the results of the assessment of risk factors related to HIV infection;
- (b) recommend the HIV-related testing of the child on the basis that one or more risk factors related to HIV infection exist;
- (c) request that the parent or guardian provide the authorized agency within 10 business days with written permission to refer the child for the HIV-related testing;
- (d) provide the opportunity for the parent or guardian to meet with agency staff if the parent or guardian objects to such testing in order to discuss the importance of early treatment for a child with HIV infection;
- (e) if the parent or guardian of the child who lacks capacity to consent provides the agency with written permission for the child to be referred for HIV-related testing, and the child has been placed in foster care voluntarily by the parent or guardian in accordance with section 384-a of the Social Services Law, or the child has been placed in foster care as a juvenile delinquent in accordance with article 3 of the Family Court Act or as a person in need of supervision in accordance with article 7 of the Family Court Act, arrange for the HIV-related testing of the child including obtaining the necessary pre-test counseling for the parent or guardian, written informed consent of the parent or guardian, and post-test counseling for the parent or guardian in accordance with article 27-F of the Public Health Law;
- (f) if the parent or guardian of the child who lacks capacity to consent does not provide written permission for the child to be referred for HIV-related testing and/or the necessary written informed consent for such testing, and the child has been placed in foster care voluntarily by the parent or guardian in accordance with section 384-a of the Social Services Law, or the child has been placed in foster care as a juvenile delinquent in accordance with article 3 of the Family Court Act or as a person in need of supervision in accordance with article 7 of the Family Court Act, continue, as part of the on-going casework contacts with the parent or guardian, to discuss the importance of HIV-related testing of the child or seek a court order authorizing HIV-related testing of the child if there is an urgent medical necessity for such testing or if the parent or guardian of the child cannot be located, is incapacitated or is deceased;
- (g) if the parent or guardian of the child who lacks capacity to consent provides the agency with written permission for the child to be

referred for such testing, and the child has been found by the family court to be an abused or a neglected child pursuant to article 10 of the Family Court Act or has been taken into or kept in protective custody or removed from the place where the child was residing pursuant to section 417 of the Social Services Law or section 1022, 1024 or 1027 of the Family Court Act, the designated staff must arrange for the HIV-related testing of the child including either:

- (1) obtaining the necessary pre-test counseling for the parent or guardian, written informed consent of the parent or guardian, and post-test counseling for the parent or guardian in accordance with article 27-F of the Public Health Law; or
  - (2) contacting the commissioner of the social services district in whose care and custody the child is placed, or the commissioner's designated representative, who must provide the necessary written informed consent for the HIV-related testing of the child;
- (h) if the parent or guardian of the child who lacks capacity to consent does not provide written permission for the child to be referred for HIV-related testing within 10 business days of the request, and the child has been found by the family court to be an abused or a neglected child pursuant to article 10 of the Family Court Act or has been taken into or kept in protective custody or removed from the place where the child was residing pursuant to section 417 of the Social Services Law or section 1022, 1024 or 1027 of the Family Court Act, the designated agency staff must contact the commissioner of the social services district in whose care and custody the child is placed, or the commissioner's designated representative, who must provide the necessary written informed consent for the HIV-related testing of the child. Upon the issuance of such written informed consent by the commissioner or the commissioner's designated representative, the authorized agency must arrange for the HIV-related testing of the child.
- (5) Conducting and timing of the HIV-related testing.
- (i) The HIV-related testing may be conducted at designated testing centers or other medical facilities, by licensed medical personnel including medical staff employed by the authorized agency, or in connection with a comprehensive medical examination of the child.
  - (ii) If the necessary written informed consent for the HIV-related testing of a child has been obtained in accordance with paragraph (4) of this subdivision, the HIV-related testing must occur:
    - (a) within 30 business days of the child's entry into foster care if the child entered foster care on or after September 1, 1995, and it was

determined within five business days of the child's entry into foster care that there was no possibility that the child had the capacity to consent to HIV-related testing; or

- (b) within 60 business days of the child's entry into foster care if the child entered foster care on or after September 1, 1995, and it was determined within five business days of the child's entry into foster care that there was a possibility that the child had the capacity to consent to HIV-related testing; or
- (c) by or at the time of the child's next scheduled periodic medical examination or the child's next service plan review, whichever occurs sooner, if the child entered foster care before September 1, 1995.

(6) Additional assessments of a child in foster care.

- (i) Each service plan review of a child that occurs after the initial assessment of the child pursuant to paragraph (2) of this subdivision must include an assessment by designated agency staff of whether HIV-related testing of the child is recommended based on the child's medical history and any information regarding the child obtained since the initial assessment of the child, the prior service plan review of the child or the prior periodic medical examination of the child, as applicable.
- (ii) Each periodic medical examination of a child required pursuant to subdivision (f) of this section that occurs after the initial assessment of the child pursuant to paragraph (2) of this subdivision must include an assessment by designated agency staff of whether HIV-related testing of the child is recommended based on the child's medical history and any information regarding the child obtained since the initial assessment of the child, the prior service plan review of the child or the prior periodic medical examination of the child, as applicable.
- (iii) If it is determined at a service plan review or periodic medical examination of the child that HIV-related testing of the child is recommended, the authorized agency must initiate the process set forth in paragraph (4) of this subdivision to arrange for the HIV-related testing of the child. If the necessary written informed consent for the HIV-related testing of the child is obtained, the authorized agency must arrange for the HIV-related testing of the child within 30 business days of the recommendation.

(7) Medical services and counseling. If a child tests positive for HIV infection, the authorized agency must:

- (i) arrange for any additional HIV-related testing of the child necessary to verify the existence of HIV infection including obtaining the necessary written informed consent for such additional HIV-related testing in accordance with paragraph (4) of this subdivision;

- (ii) refer the child for appropriate medical services; and
  - (iii) provide or arrange for appropriate psychological and other support services for the child and/or the child's family and/or the child's foster family, as applicable.
- (8) Documentation of HIV-related testing of a child in foster care. Information regarding any HIV-related testing of a child in foster care and the results of such testing must be documented in the medical history of the child within the uniform case record in accordance with sections 428.3(b)(4)(ii) and 441.22(k)(5) of this Title. Such information must be provided only to those persons or entities authorized to have access to HIV-related information concerning the foster child in accordance with subdivision (o) of this section, section 357.3 of this Title, and article 27-F of the Public Health Law, including:
- (i) the certified or approved foster parents or prospective adoptive parents of the child in accordance with section 357.3 of this Title and section 373-a of Social Services Law;
  - (ii) the child, if the child is determined to have capacity to consent as defined in paragraph (1) of this subdivision and in article 27-F of the Public Health Law; and
  - (iii) the parents or guardian of the foster child, except that, if the child is determined to have capacity to consent, the child's written release for such disclosure must be obtained in accordance with section 360-8.1(g) of this Title before any information concerning the HIV-related test is provided to the child's birth parents or guardian.
- (9) Recruitment of families to provide foster or adoptive homes for HIV-infected children. Authorized agencies operating foster boarding home programs or adoption programs must include in their community relations recruitment efforts, as required by sections 421.10 and 443.2 of this Title, information regarding the need for families who are able and motivated to care for HIV-infected foster children when such need is indicated as a result of the assessment and testing required by this subdivision.
- (c) (1) Initial medical examination upon admission into foster care. Each child admitted into foster care must be given a comprehensive medical examination within 30 days after admission. When records are available to document that such an examination has been completed within 90 days prior to admission into care, and the authorized agency has obtained such records and determines that the child's health status does not warrant a second comprehensive examination within 30 days after admission into foster care, the local social services district may waive the initial medical examination required by this paragraph.
- (2) When an initial medical examination is required, the examination must be comprehensive in accordance with current recommended medical practice, taking into account the age, environmental background and development of the child. Such an examination must include the following:

- (i) a comprehensive health and developmental history;
- (ii) a comprehensive unclothed physical examination;
- (iii) an assessment of the child's immunization status and the provision of immunizations as necessary;
- (iv) an appropriate vision assessment;
- (v) an appropriate hearing assessment;
- (vi) appropriate laboratory testing;
- (vii) a dental screening; and
- (viii) observation for child abuse and maltreatment which, if suspected, must be reported to the State central register of child abuse and maltreatment as mandated by section 413 of the Social Services Law.

Laboratory tests may include complete blood count, urinalysis, tuberculin skin test, X-rays, HIV related tests, where performed in a manner consistent with article 27-F of the Public Health Law, and lead, sickle cell, and venereal disease screening at the direction of a physician when indicated on the basis of the child's age, medical history, environmental background and physical/developmental condition.

- (3) The comprehensive medical examination described in paragraph (2) of this subdivision must be completed within 30 days:
  - (i) after a child is accepted into foster care, unless records are available to document that such an examination has been completed within 90 days prior to admission into care and the initial medical examination is waived by the authorized agency; or
  - (ii) after a foster child returns to foster care if more than 90 days have passed and the child:
    - (a) was discharged from care, either on a trial basis or on a permanent basis; or
    - (b) was absent from care without leave.
- (4) The comprehensive medical examination described in paragraph (2) of his subdivision may be conducted at any time at the discretion of the authorized agency when:
  - (i) there are concerns about a foster child's health when such child returns to care within 90 days after:
    - (a) being discharged from care, either on a trial basis or on a permanent basis; or
    - (b) being absent from care without leave; or

- (ii) a child is transferred to the care of another agency and the receiving agency determines that a comprehensive medical examination may be necessary to assist in the formulation of the child's service plan.
- (d) Prior to accepting a foster child into care in cases of voluntary placement, or within 10 days after admission into care in emergency or court- ordered placements, authorization in writing must be requested from the child's parent or guardian for routine medical and/or psychological assessments, immunizations and medical treatment, and for emergency medical or surgical care in the event that the parent or guardian cannot be located at the time such care becomes necessary. Such authorization must become a permanent part of the child's medical record. If written authorization cannot be obtained from the child's parent or guardian in cases of involuntary placements, the local social services commissioner may provide written authorization where authorized in accordance with section 383-b of the social services law.
- (e) Prior to accepting a child into care or within 10 days after admission into care, 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. Diligent efforts must be made by the authorized agency to obtain such records by submitting a written request, along with the appropriate authorization, to the various doctors and/or hospitals known to have previously treated the child. When a preschool child is placed in foster care, diligent efforts must be made to obtain the child's birth record from the hospital where the child was born or from another hospital in possession of such record. Upon receipt, such record must be included in the uniform case record.
- (f) (1) Each foster child must have complete periodic individualized medical examinations, the results of which must be maintained in the child's uniform case record. Such examinations must be provided according to the following schedule:
  - (i) for children aged 0-1 year: at 2-4 weeks; 2-3 months; 4-5 months; 6-7 months; 9-10 months;
  - (ii) for children aged 1-6 years: at 12-13 months; 14-15 months; 16-19 months; 23-25 months; 3 years; 4 years; 5 years; and
  - (iii) for children aged 6-21 years: at 6 years; 8-9 years; 10-11 years; 12-13 years; 14-15 years; 16-17 years; 18-19 years; and 20 years.
- (2) Such examinations must follow current recommended medical practice and be consistent with the needs of the child as determined by the child's physician. Every examination must include the following, as appropriate by age:
  - (i) a comprehensive health and developmental history;
  - (ii) a comprehensive unclothed physical examination;
  - (iii) an assessment of immunization status and provision of immunizations as necessary;

- (iv) at each periodic medical examination of a child that occurs after the initial assessment of the child for risk factors related to HIV infection in accordance with subdivision (b) of this section, an assessment of whether HIV-related testing of the child is recommended based on the child's medical history and any information regarding the child obtained since the initial assessment of the child, the prior service plan review of the child or the prior periodic medical examination of the child, as applicable.
  - (v) an appropriate vision assessment;
  - (vi) an appropriate hearing assessment;
  - (vii) laboratory tests as appropriate for specific age groups or because the child presents a history or symptoms indicating such tests are necessary;
  - (viii) dental care screening and/or referral. All children up to age three should have their mouths examined at each medical examination and, where appropriate, should be referred for dental care. All children three years of age or over must have a dental examination by a dentist annually and must be provided with any dental care as needed; and
  - (ix) observation for child abuse and maltreatment which, if suspected, must be reported to the State central register of child abuse and maltreatment as mandated by section 413 of the Social Services Law.
- (g) When the medical examination indicates a condition requiring follow-up care as determined by the child's physician, the agency responsible for the child's care must provide or arrange for such follow-up care as recommended by the child's physician.
- (h) (1) Within 60 days of the acceptance into foster care of a child who is eligible for medical assistance, the local social services district must notify in writing the child's foster parent(s), or the institution, group residence, group home or agency boarding home where the child is residing of the availability of child/teen health plan services (C/THP). All families eligible for C/THP services must also be informed in writing at least annually of the availability of such services in accordance with section 508.4(a) of this Title.
- (2) The local social services district is responsible for assuring that a current listing of the names and locations of medical providers offering examinations, diagnosis and treatment to children eligible for C/THP is made available to foster parents and to other authorized agencies upon request.
- (i) For a foster child placed with a child-caring agency having an established Medicaid per diem rate agreement, C/THP services must be provided in accordance with that agency's per diem rate agreement and may not be claimed separately.
- (j) (1) Each authorized agency responsible for the care of a child must inform the foster parent(s) of the comprehensive health history, current health status and health care needs of the foster child when the child is placed in the home, including:
- (i) the requirements for type and frequency of medical examinations;

- (ii) the agency's procedures for obtaining medical care in cases of suspected illness;
  - (iii) the agency's procedures for securing emergency medical treatment; and
  - (iv) information related to whether the child has had an HIV related test or been diagnosed as having AIDS, and HIV related illness or an HIV infection. The terms AIDS, HIV related test, HIV related illness and HIV infection are defined in section 360-8.1 of this Title.
- (2) Each authorized agency must inform the foster parent(s) that assistance is available in scheduling appointments with and providing transportation to providers of medical care on behalf of the foster children placed in their care if such assistance is requested.
- (k) For each child in foster care, an authorized agency must maintain a continuing individual medical and dental history within the uniform case record, which must include:
- (1) Form DSS-711, Child's Medical Record, or copies of a comparable physician's medical record form. Such form must record the results of the initial medical examination and must be maintained as a continuous and permanent medical history for children placed in foster care. For children in the care of a voluntary agency for whom the local social services district has responsibility, the agency must maintain a continuous and permanent medical and dental history, and the local social services district must maintain a current copy of such history in its files.
  - (2) Form DSS-704, Medical Report on Mother and Infant. Such form must be used to record the child's birth history, as available from the appropriate hospital, for each preschool child placed in foster care, either in the direct care of the local social services district or in the care of voluntary agencies.
  - (3) Form DSS-3306, Progress Notes. Such form must be maintained in the uniform case record by the agency providing care to a child and must include a summary of activities related to medical and dental appointments, examinations and services, including records of referrals and transportation provided.
  - (4) Timely entry of the appropriate data related to medical examination appointments.
  - (5) Documentation that an assessment has been made in accordance with subdivision (b) of this section for risk factors related to HIV infection, and that, if one or more risk factors have been identified, procedures have been followed to obtain the necessary written informed consent and to arrange for the HIV-related testing of the child. Results of such testing must be included in the medical history of the child within the uniform case record.
- (l) (1) Each foster parent providing care for an adolescent who is 12 years of age or over must be informed in writing within 30 days of placement of the child in the home, and annually thereafter, of the availability of social, educational and medical family planning services for the adolescent in accordance with section 463.2 of this Title.
- (2) Each authorized agency, in accordance with section 463.2 of this Title, may, with the prior approval of the local commissioner of social services or upon the delegation of such

responsibility by the local social services district, make the offer of family-planning services to all foster children for whom such services would be appropriate and provide such services upon request of the foster child. Such offer may be made orally as long as it is also made in writing.

- (m) Upon the transfer of any foster child to the care of another voluntary agency, the agency with which the child was previously placed must provide to the receiving agency a summary of the child's health history and the medical records received from the child's physician.
- (n) Medical examination upon discharge from care. Each child discharged from care according to a permanency planning goal of independent living must have a comprehensive medical examination prior to discharge, unless the child has undergone such an examination within one year prior to the date of discharge.
- (o) Upon a child's discharge from foster care, the local social services district is responsible for ensuring that:
  - (1) in accordance with section 357.3 of this Title, a comprehensive health history of the child is provided to the child's parents or guardian or to a child if the child is discharged to his or her own responsibility. Such a history must include, but not be limited to, conditions or diseases believed to be hereditary, where known; drugs or medication taken during pregnancy by the biological mother, where known; immunizations received by the child in foster care and prior to placement in care, where known; medications dispensed to the child while in care and prior to placement in care, where known; allergies the child is known to have exhibited while in care and prior to placement in care, where known; diagnostic tests, including developmental or psychological tests and evaluations given to the child while in care and prior to placement in care, where known, and their results; any follow-up treatment provided to the child prior to placement in care, where known, or provided to the child while in care or still needed by the child; and laboratory tests, including tests for HIV, and the results, where known, except that confidential HIV-related information must not be disclosed to the child's parent or guardian without a written release from the child if the child has capacity to consent as defined in section 360-8.1(a)(8) of this Title and in article 27-F of the Public Health Law. The conditions for the written release authorizing such disclosure are described in section 360-8.1(g) of this Title and in article 27-F of the Public Health Law. The term confidential HIV-related information is defined in section 360-8.1(a)(5) of this Title and in article 27-F of the Public Health Law.
  - (2) the importance of comprehensive and periodic medical assessments and follow-up treatment is discussed with the child's parents or guardian, or with children discharged to their own care;
  - (3) assistance is offered to the child's parent(s) or guardian or the child in finding a physician or medical provider organization in an appropriate location through referrals to and/or lists of such medical providers required to be maintained by social services districts in accordance with section 508.6 of this Title;
  - (4) diligent effort is made to obtain the name and address of the physician or medical organization who will be providing medical services to the child; and

- (5) a copy of the child's comprehensive health history is provided to the child's medical provider when identified.
  
- (p) If a foster child is discovered to have an elevated blood lead level, the authorized agency is responsible for notifying the department and the local health department.

Revisions

(8/9/92 subd. (n), para. (1) amended.)

(6/8/94 subd. (j), para. (4) amended.)

(8/31/94 subd. (o) is added.)

(09/01/94 subds. (b) through (o) relettered (c) through (p) and a new subd. (b) is added; subd. (f), para. (1), subpara. (iv) repealed, subpara. (iii) amended; subd. (f), para. (2), subparas. (iv) through (viii) are redesign. subparas. (v) through (ix) and a new subpara. (iv) is added; subd. (k), para. (5) is added.)

(12/01/94 same as above.)

(08/04/95 same as above.)



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### 442.11. Health facilities. [Institutions]

- (a) Rooms for medical examinations. A room or rooms shall be provided for medical examinations, nurse's office, first aid and other treatment. The room or rooms shall be adequately furnished and equipped to fulfill their function, and shall be used for no other purpose.
- (b) Rooms for care of children with minor illnesses. Children with minor illnesses not requiring hospital care shall be cared for in a room or rooms not occupied by children who are not ill.
- (c) Hospital facilities. Institutions which operate hospital facilities in addition to an institution for children shall comply with requirements with respect to the hospital facilities.
- (d) Isolation facilities. Facilities for the isolation of children with communicable disease shall be equipped for the efficient care of such children and maintained in a manner to prevent the spread of disease.
- (e) First aid supplies, as recommended by staff physician, shall be readily available.
- (f) All drugs, medicines and instruments shall be kept in a locked cabinet and a system of controls shall be maintained under the supervision of a physician or nurse.

### 442.21 Health and medical services. [Institutions]

- (a) Each institution must provide or arrange for appropriate medical and nursing care for children in foster care in accordance with this section and section 441.22 of this Title.
- (b) All medical and nursing care shall be provided by persons having the qualifications set forth in this Part.
- (c) Each institution shall comply with the provisions of article 25 of the Public Health Law relating to institutions for children.
- (d) Each institution shall provide for the proper isolation of children with communicable or infectious diseases.
- (e) An institution primarily serving children under 12 shall have on its staff, or otherwise make provision for the services of, a pediatrician.
- (f) Each institution serving 50 or more children shall employ a nurse.
- (g) Each child will be provided, when necessary, with eyeglasses, hearing aids, and prosthetic or other adaptive devices.
- (h) Written procedures concerning the actions to be taken in a medical emergency will be made known to staff and volunteers of an institution.
- (i) (1) The agency must always have on duty at least one person at each site operated by an institution for each shift who is certified by the American Red Cross as trained in first aid. All child care staff whose duties are predominantly recreational in nature must be certified by the American Red Cross as trained in first aid.

- (2) All nursing staff employed by an institution must be certified by the American Red Cross as trained in first aid and cardiopulmonary resuscitation techniques.
  
- (j) A first aid kit must be made available for each living unit in an institution. The contents of the kit will be appropriate to the needs of the children served and be approved by a physician most familiar with the population of the living unit. The kits will be placed in convenient locations so that the kits are readily accessible to staff of each living unit.

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### **448.3 (f) Medical policies and procedures. [Group Homes]**

- (1) The medical policies and procedures shall be described in writing and interpreted to all the personnel of the home. They shall be subject to frequent and regular review.
- (2) Each child must have complete periodic medical examinations in accordance with section 441.22 of this Title.
- (3) Each child will be provided, when necessary, with eyeglasses, hearing aids, and prosthetic or other adaptive devices.
- (4) Written procedures concerning the actions to be taken in a medical emergency will be made known to staff and volunteers of a group home.
- (5) First aid kits will be provided in such numbers as are necessary to meet the needs of the children in each group home. The contents of the kit will be appropriate to the needs of the children served and be approved by a physician most familiar with the population of each group home. The kits will be placed in convenient locations, so that the kits are readily accessible to staff of each group home.
- (6) Whenever a group home is located more than five miles from any facility which can provide medical services in an emergency, all child care personnel of the group home must be certified in first aid by the American Red Cross. If a group home is located five miles or less from any facility which can provide medical services in an emergency, the agency must make reasonable efforts to have one person on each shift who is certified by the American Red Cross as trained in first aid.
- (7) During a period of one month following the birth of her child, no mother in a facility caring for mothers and their children may engage in work, work training, school or any other program which requires her to be away from the home, without written approval from a physician.



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### PART 507

#### HEALTH SUPERVISION AND MEDICAL CARE FOR CHILDREN

(Statutory authority: Social Services Law, Sections 20, 34, 350, 364, 365-a, 462)

507.1 General responsibilities for health supervision and medical care for children

507.2 Special assessments, examinations and tests required for children in foster care

507.3 Payment for health supervision and care

507.4 Medical rehabilitation and mental health

507.5 Emergency medical treatment for children in foster care

#### **507.1 General responsibilities for health supervision and medical care for children.**

(a) It is the responsibility of the local social services district to provide for comprehensive medical services for children in foster care and to assure the availability and encourage the utilization of such services for children receiving services under a public assistance program. This responsibility will be jointly shared by the medical assistance unit and the children's services and public assistance staffs.

(b) Administratively, the provision of medical care for children must be carried out in accordance with other provisions of this Subchapter and section 43.6 of this Title.

(c) For children in foster care, health supervision is a continuing responsibility of the children's services caseworker and medical assistance staff of the local social services district. Such responsibility includes:

(1) procuring, recording and maintaining information regarding the health history, current health status, and health care needs of the children in care;

(2) arranging for periodic medical and dental examinations according to the following schedule:

(i) for children aged 0-1 years: at 2-4 weeks; 2-3 months; 4-5 months; 6-7 months; 9-10 months;

(ii) for children aged 1-6 years: at 12-13 months; 14-15 months; 16-19 months; 23-25 months; 3 years; 4 years; 5 years; and

(iii) for children aged 6-21 years: at 6 years; 8-9 years; 10-11 years; 12-13 years; 14-15 years; 16-17 years; 18-19 years; 20 years;

(3) arranging for periodic medical and dental examinations that must follow current recommended medical practice and be consistent with the needs of the child as determined by the child's physician. Every examination must include the following as appropriate by age:

(i) a comprehensive health and developmental history;

(ii) a comprehensive unclothed physical examination;

(iii) an assessment of immunization status and provision of immunizations as necessary;

(iv) an appropriate vision assessment;

(v) an appropriate hearing assessment;

(vi) laboratory tests as appropriate for specific age groups or because the child presents a history or symptoms indicating such tests are necessary;

(vii) dental care screening and/or referral. All children up to age three should have their mouths examined at each medical examination and where appropriate should be referred for dental care. All children three years of age or over must have a dental examination by a dentist annually and must be provided with any dental care as needed; and

(viii) observation for child abuse and maltreatment which, if suspected, must be reported to the State Central Register of Child Abuse and Maltreatment as mandated by section 413 of the Social Services Law;

(4) for a child who is eligible for medical assistance, notifying the foster parent(s), or the institution, group residence, group home, or agency boarding home where the child is residing, in writing within 60 days of acceptance of the child into foster care of the availability of child/teen health plan services (C/THP) and providing upon request the names and locations of providers offering examinations, diagnosis and treatment to children eligible for C/THP. All families eligible for C/THP services must also be informed at least annually of the availability of such services in accordance with section 508.4 of this Title;

(5) informing foster parents that assistance is available in scheduling appointments with and providing transportation to providers of medical care on behalf of their foster children if such assistance is requested;

(6) consulting with physicians, dentists, psychologists and other professional staff, as appropriate, regarding the significance of information and findings;

(7) determining actions to be taken to carry out treatment recommendations;

(8) in accordance with section 463.2 of this Title, advising in writing each foster parent providing care to an adolescent who is 12 years of age or over of the availability for such child of social, educational and medical family planning services;

(9) providing or arranging, in accordance with section 463.2 of this Title, requested family planning services within 30 days of such request; and

(10) when a child-caring agency is authorized by a local social services district to offer family planning services to a foster child who is 12 years of age or over in accordance with section 463.2 of this Title, monitoring the provision of information and services and assuring that reports and data on such services are included in the uniform case record.

(d) For a child receiving services under a public assistance program, the local social services district is responsible for making available prompt and adequate medical and dental examinations and treatment in accordance with Part 508 of this Title, and in educating the parent(s), guardian or other relative caring for the child on the necessity for health supervision of the child.

(e) Records. (1) For a child placed in foster care, Form DSS-711, Child's Medical Record, or an appropriate physician's medical record form must be used to report the results of the initial physical examination and also must be maintained as a continuous and permanent medical history of the child. For a child placed in the care of a voluntary agency for whom the local social services district has responsibility, the voluntary agency must maintain a continuous and permanent medical and dental history and the local social services district must maintain a copy of such history in its files.

(2) Form DSS-704, Medical Report on Mother and Infant, must be used to record the child's birth history, as available from the appropriate hospital, for each preschool child placed in foster care, either in the direct care of the local social services district or in the care of voluntary agencies. Such form must be included in the uniform case record as part of the continuous medical history for the child.

(3) Form DSS-3306, Progress Notes, must be maintained in the uniform case record by the agency providing care to the child and must include a summary of activities related to medical and dental appointments, examinations and services, including records of referrals as specified in section 428.5 of this Title.

(4) For children receiving public assistance, all medical reports from physicians or other sources must be maintained in the case record so that a continuous medical history may be available at all times.

#### **507.2 Special assessments, examinations and tests required for children in foster care.**

(a) Assessment of each child in foster care for risk factors related to HIV infection.

(1) Each child placed in foster care must be assessed for risk factors related to HIV infection in accordance with section 441.22(b) of this Title as follows:

(i) Each child entering foster care on or after September 1, 1995, must be assessed for risk factors related to HIV infection within five business days of entry into care if it is determined within five business days of entry into care that there is no possibility that the child has capacity to consent to HIV-related testing, or within 30 business days of entry into care if it is determined within five business days of entry into care that there may be a possibility that the child has capacity to consent to HIV-related testing.

(ii) Each child who entered foster care prior to September 1, 1995, must be assessed for risk factors related to HIV infection within 60 business days of the next periodic medical examination required for the child according to the schedule for periodic medical examinations provided in section 441.22(f) of this Title or within 60 business days of the child's next service plan review date, whichever occurs sooner.

(iii) In addition, each service plan review of a child and each periodic medical examination of a child required pursuant to section 441.22(f) of this Title that occurs after the initial assessment of the child for risk factors related to HIV infection must include an assessment of whether HIV-related testing of the child is recommended based on the child's medical history and any available information regarding the child obtained since the initial assessment of the child, the prior service plan review of the child or the prior periodic medical examination of the child, as applicable.

(2) If the child is determined through the required assessment to have one or more risk factors for HIV infection or if the child's medical provider recommends the HIV-related testing of the child, designated agency staff must initiate the process to arrange for the HIV-related testing of the child in accordance

with section 441.22(b) of this title including obtaining the necessary written informed consent for such testing.

(b) (1) Initial medical examination. Within 30 days of admission into foster care, each child must be given an initial comprehensive medical examination. When records are available to document that such an examination has been completed within 90 days prior to admission into care, and the authorized agency has obtained such records and determines that the child's health status does not warrant a second comprehensive examination within 30 days after admission into foster care, the local social services district may waive the initial medical examination required by this paragraph.

(2) When an initial medical examination is required, the initial medical examination must be comprehensive in accordance with standards of the American Academy of Pediatrics, taking into account the age, environmental background and development of the child. Such an examination must include the following:

(i) a comprehensive health and developmental history;

(ii) a comprehensive unclothed physical examination;

(iii) an assessment of the child's immunization status and the provision of immunizations as necessary;

(iv) an appropriate vision assessment;

(v) an appropriate hearing assessment;

(vi) appropriate laboratory tests;

(vii) a dental screening; and

(viii) an observation for child abuse and maltreatment which, if suspected, must be reported to the State Central Register of Child Abuse and Maltreatment as mandated by section 413 of the Social Services Law.

Laboratory tests may include complete blood count, urinalysis, tuberculin skin test, X-rays, HIV related tests, where performed in a manner consistent with article 27-F of the Public Health Law, and lead, sickle cell and venereal disease screening at the direction of a physician when indicated on the basis of the child's age, medical history, environmental background and physical/developmental condition.

(3) The comprehensive initial examination described in paragraph (1) of this subdivision must be completed within 30 days:

(i) after a child is accepted into foster care, unless records are available to document that such an examination has been completed within 90 days prior to admission into care and the initial medical examination is waived by the authorized agency; or

(ii) after a foster child returns to foster care if more than 90 days have passed and the child:

(a) was discharged from care, either on a trial basis or on a permanent basis; or

(b) was absent from care without leave.

(4) The initial medical examination described in paragraph (1) of this subdivision may be completed at the discretion of the authorized agency when:

(i) there are concerns about a foster child's health condition when such child returns to care within 90 days after:

(a) being discharged from care, either on a trial basis or permanent basis; or

(b) being absent from care without leave; or

(ii) a child is transferred to the care of another agency, and the receiving agency determines that a comprehensive medical examination may be necessary to assist in the formulation of the child's service plan.

(c) Discharge to independent living. Prior to the child's discharge from foster care according to a permanency planning goal of independent living, such child must have a comprehensive medical examination in accordance with sections 441.22 of this Title, and 507.1 of this Part, unless the child has undergone such an examination within one year prior to the date of discharge.

(d) Adoption. (1) When a child in foster care is freed for adoption or has a permanency planning goal of adoption, a comprehensive medical examination in accordance with sections 441.22 of this Title and 507.1 of this Part must be completed prior to adoptive placement unless the child has undergone such an examination within six months prior to the adoptive placement.

(2) Consideration must be given to the desirability of psychiatric or psychological evaluation or consultation for a child in foster care prior to adoptive placement, and when deemed advisable, such evaluation or consultation shall be carried out and included in the comprehensive health history of the child.

### **507.3 Payment for health supervision and care.**

(a) Medical services.

(1) Fee schedules. The fee schedules of the department shall prevail for purposes of reimbursement in accord with the policies of the department.

(2) Pediatric care. When children are placed under the care of a qualified pediatrician for child health supervision and regular medical care, that pediatrician shall be considered to be the personal physician to that child. His fees shall be governed by the fee schedule.

#### **507.4 Medical rehabilitation and mental health.**

(a) Medical rehabilitation. Children with handicapping physical defects, including physically handicapping malocclusion, the nature of which may make them eligible for care under the physically handicapped children's program of the State Department of Health shall be referred promptly to the local medical rehabilitation director for determination of medical eligibility for such program. If a child is determined to be medically eligible therefor, the local social services official shall determine financial eligibility for medical assistance. If the case is determined to be fully eligible financially for medical assistance, the medical services shall be authorized by the local social services official and payments for such services shall be made in full from medical assistance funds. If, however, the social services official determines that the case is not fully eligible financially and that the child's parents are required to contribute toward the cost of his care under medical assistance eligibility standards, the case shall be referred for payment for that care to the physically handicapped children's program.

(b) Mental health. Utilization of available child guidance or mental health clinics, or other suitable resources, shall be arranged as indicated for children with evidence of emotional disturbance or behavior disorder.

#### **507.5 Emergency medical treatment for children in foster care.**

Social services officials shall establish a procedure under which an immediate determination as to permission for emergency medical treatment will be sought from the person having custody of a child for each child for whom a district provides or purchases foster care; immediate determinations will be sought when emergency medical treatment is necessary and the provider of medical services requires a consent. Each local social services department shall assure that:

(a) procedures are developed and implemented for receiving requests for consent, and obtaining prompt consent, at any hour of the day or night;

(b) foster parents are fully informed of those procedures at the time of placement; and

(c) consents are promptly made available to the provider.

## 18 NYCRR

### PART 508 CHILD/TEEN HEALTH PLAN (C/THP)

(Statutory authority: Social Services Law, Sections 20, 34, 153, 350, 364, 365-a)

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#### **508.0 Scope.**

This Part describes the Child/Teen Health Plan

(C/THP), the eligibility criteria for providers and recipients of C/THP services, the requirements of a C/THP examination and the responsibility of the C/THP provider in fulfilling those requirements, and the reimbursement provisions.

#### **508.1 Definitions.**

As used in this Part:

(a) Child/Teen Health Plan (C/THP), formerly known as the Child Health Assurance Program (CHAP), means a program established and administered by local social services districts which is directed toward assisting eligible persons to receive ongoing primary and preventive health care in order to discover any physical and mental problems and to provide treatment to correct or ameliorate such problems or chronic conditions through the provision of the following services:

(1) early and periodic screening and diagnosis of eligible persons are regularly scheduled examinations and evaluations of the general physical and mental health, growth development and nutritional status of infants, children and youth. At a minimum, early and periodic screening and diagnosis must include, but is not limited to, the development of a comprehensive health and developmental history, a comprehensive unclothed physical examination, an appropriate vision and hearing test, appropriate laboratory tests and dental screening services furnished by direct referral to a dentist for children beginning at three years of age, as described in section 508.8 of this Part;

(2) inter-periodic screens; and

(3) treatment or referral for treatment for conditions including, but not limited to, defects in vision and hearing, including eyeglasses and hearing aids, dental care needed for the relief of pain and infections, restoration of teeth and maintenance of dental health, and appropriate immunizations, as described in section 508.8 of this Part.

(b) A continuing care provider for the purposes of the C/THP means a provider who has a written agreement with the department or a local social services district to provide at least the services described in section 508.12 of this Part to persons eligible for C/THP services formally enrolled with the provider.

(c) Date eligibility as determined means the certification date for medical assistance eligibility entered by the local social services district on the applicant's record, i.e., the date the supervisor signed the authorization. This date may be prospective or retroactive from the effective date of eligibility.

(d) The department means the New York State Department of Social Services.

(e) Oral informing means information provided to persons eligible or potentially eligible for C/THP services, including face-to-face conversation by local social services district workers, health aides and providers, as well as other forms of communication such as public service announcements, community awareness campaigns, audio-visual films, filmstrips and video tapes.

(f) Periodicity schedule means a schedule of comprehensive child health examinations.

(g) Persons eligible for C/THP services means persons under 21 years of age who are in receipt of medical assistance.

(h) Referral means the process of (1) directing an eligible person to a provider for a needed service after it has been confirmed that the provider is accessible and can provide the needed service to that person without undue delay, and (2) conducting a follow-up in a timely manner to determine whether the service was obtained and to provide an alternative referral if necessary.

### **508.2 General policy.**

(a) Each local social services district will establish and administer a C/THP for its district, directly or through a contract, in accordance with a plan submitted to and approved by the department. Revisions or amendments to the district's initial C/THP plan must be submitted in writing to the department for approval. Revisions must be approved by the department prior to being implemented.

(b) Each local social services district must assemble an outreach advisory council which will meet at least annually to develop and monitor a plan for increasing the number of eligible persons participating in C/THP. The council must include providers of medical services, consumers, advocates, and representatives of local health departments, and must report to the State Commissioner of Social Services annually on the character and effectiveness of local outreach initiatives. The first report should be submitted no later than 12 months from the effective date of this Part (May 16, 1988).

### **508.3 Identification of persons eligible for C/THP services.**

Each local social services district will maintain a system which would enable the district to monitor the status of each person participating in the C/THP, and which would enable the district to identify persons who are eligible to participate in the C/THP.

### **508.4 Informing persons eligible for C/THP services about C/THP.**

(a) Each local social services district must inform each household with children or a person or persons having legal custody of a child eligible for C/THP services, in writing, of the availability of C/THP services no later than 60 days following:

- (1) the date initial eligibility for C/THP is determined;
- (2) the date eligibility is determined after a 12-month or longer period of ineligibility; or
- (3) the date a person eligible for C/THP services is added to a case. All persons eligible for C/THP services must be informed in writing at least annually after eligibility is determined of the availability of C/THP services.

(b) In addition to the requirements of subdivision (a) of this section, all persons eligible for C/THP services, except persons receiving supplemental security income or foster care services, must be informed orally of the availability of C/THP services no later than 90 days following:

- (1) the date initial eligibility is determined;
- (2) the date eligibility is determined after a 12-month or longer period of ineligibility; or
- (3) the date a person eligible for C/THP services is added to a case.

(c) Each local social services district must maintain written documentation of the names and medical assistance identification numbers of households informed about the availability of C/THP services, and the dates such households were informed.

(d) Each local social services district must ensure that procedures are in place in the district for informing persons who are illiterate, blind, deaf, or who cannot understand the English language, about the C/THP services and benefits.

(e) Both the written notification and oral informing will include the following information:

- (1) the benefits of preventive health services;
- (2) where and how C/THP services can be obtained;
- (3) the periodic C/THP examination services offered by the C/THP;
- (4) that treatment services available under the medical assistance program will be provided to persons eligible for C/THP services for problems discovered during the C/THP examination;

(5) that the local social services district will offer and provide assistance with transportation to persons eligible for C/THP services for medical or dental services if such assistance is requested;

(6) that the local social services district will offer and provide assistance in scheduling appointments with providers of medical or dental services if such assistance is requested; and

(7) that C/THP services are available at no cost.

(f) Any material developed by a local social services district which will be used to inform persons eligible for C/THP services about C/THP services must be approved by the department.

#### **508.5 Provision of C/THP services.**

(a) All persons eligible for C/THP services requesting examinations, diagnosis and treatment under C/THP will be given the names and locations of providers offering such services and will be informed that assistance is available for scheduling appointments with those providers if such assistance is requested, and that assistance with transportation services is available under the medical assistance program if such assistance is requested.

(b) The initial C/THP examinations must be provided within 90 days, a dental visit must be provided within 120 days, and initiation of treatment for identified medical or physical conditions must be provided within six months of the date of the request for services or of the date eligibility is determined if the request for services is made prior to a determination of eligibility.

(c) The local social services district must offer C/THP services to households containing children whose names appear on the State semiannual outreach report described in section 508.10(b) of this Part.

(d) The local social services district is not required to provide a C/THP examination to a person eligible for C/THP services if there exists written verification from the department, or from a provider authorized to provide services under the C/THP, which indicates that the most recent age-appropriate screening services due under the periodicity schedule contained in section 508.8 of this Part have already been provided to the person eligible for C/THP services.

(e) For children three years of age and over, dental services must be furnished by a direct referral to a dentist for diagnosis and treatment.

(f) If medical or dental services which are needed as a result of conditions discovered during screening and treatment are not covered by the medical assistance program, the local social services district must provide referral assistance for these services.

#### **508.6 Identification of available providers.**

Each local social services district will identify and maintain a list of the following:

(a) Medicaid providers enrolled as C/THP providers who have agreed to perform the components of the C/THP examination according to the C/THP periodicity schedule;

(b) diagnostic and treatment facilities;

- (c) providers of dental services;
- (d) providers of prenatal care;
- (e) providers of family planning services;
- (f) hospital outpatient departments; and
- (g) free-standing clinics.

#### **508.7 Agreements with providers.**

(a) To assure maximum utilization of existing screening, diagnostic and treatment services, each local social services district may enter into written agreements for the provision of services under the C/THP with physicians or appropriate public, voluntary and proprietary agencies, such as child health clinics, neighborhood health centers, free-standing clinics, hospital outpatient departments or similar facilities that provide ambulatory pediatric care.

(b)(1) Every facility subject to article 28 of the Public Health Law must provide the examinations and services identified in section 508.8(b) of this Part to persons eligible for C/THP services if such examinations and services are provided to outpatients as well-child care services for which the facility receives reimbursement under the medical assistance program.

(2) Facilities subject to the provisions of paragraph (1) of this subdivision must provide the examination and services identified in section 508.8(b) of this Part in accordance with the periodicity schedule contained in subdivision (f) of such section, and must claim reimbursement for such examinations and services under the C/THP.

#### **508.8 Standards and periodicity.**

(a) Provision of care and services. The periodicity schedule contained in this section and the contents of the C/THP examination generally follow those recommended by the Committee on Standards of Child Health of the American Academy of Pediatrics. Appropriate modifications in the content of the examination can be made according to the attending physician's medical judgment, consistent with the needs of the individual child and current recommended standards of medical practice.

(b) Contents of an examination. Every C/THP examination should include the following as appropriate by age:

(1) Comprehensive health history.

(i) (a) For a new patient, a complete family history, social history, past medical history, and review of body systems must be obtained and recorded.

(b) When obtaining the comprehensive health history of children five years of age or younger, the history must include details of pregnancy, delivery, birth weight and the neonatal period.

(c) When obtaining the comprehensive health history of adolescents, a review of the body systems should also include a history of sexual activity and use of contraception and a menstrual history for females.

(d) For patients whose initial histories have already been recorded by the C/THP provider, the family, social and medical histories may be confined to the period since the histories were last recorded.

(ii) The histories may be obtained initially by health assistants, provided the C/THP provider reviews and supplements the histories at the time the provider conducts his or her examination of the child.

(2) Comprehensive physical examination. The examination of a person eligible for C/THP services must be performed by a licensed physician or by a physician's assistant or registered professional nurse qualified to provide primary care services under a physician's supervision, and is to consist of a systematic examination of all parts of the body, including appropriate neurological, dental, otoscopic and funduscopic examinations and observation of the back for scoliosis. Results of the physical examination must be recorded in the medical record by body regions. Blood pressure measurements must be taken for all children three years of age and older.

(3) Assessment of physical growth and nutritional status. Height and weight for all persons eligible for C/THP services, as well as head circumference for infants, are to be measured and recorded at each examination. Measurements of height and weight through the fifth year of age, and of head circumference through one year of age and again at two years of age, should be plotted on a standard growth chart, which is to be incorporated into the medical record. Plotting of measurements for older children and adolescents is recommended but not required.

(4) Assessment of mental and psychosocial development. (i) For children through five years of age, a detailed developmental history of the infant or child must be obtained and documented in the child's medical record. The history should include information relating to speech, cognitive, emotional, psychosocial and gross and fine motor development. Administration of a standardized (formal) developmental screening test, such as the Denver Developmental Screening Test (DDST) or the abbreviated DDST, is recommended but not required. The child's health status must also be updated at each periodic visit in such a way as to allow for serial evaluation.

(ii) For children 6 to 12 years of age, an assessment of the psychosocial adjustment should include a discussion of school performance and peer and family relationships.

(iii) For adolescents 13 years of age and older, an assessment of the psychosocial adjustment should include a discussion of peer and family relationships, school/job performance, use of drugs, alcohol or tobacco and sexual preparedness and activity.

(5) Vision testing. (i) For children less than three years of age, testing should include the following elements:

(a) Observation of the infant's/child's reaction to an object of interest such as a light or familiar toy for gross indication of vision. Each eye is required to be observed separately.

(b) Motility screening, including gross inspection of the eye to determine the presence of any obvious strabismus, and the cover test, which is especially valuable in patients with a small deviation from the norm.

(ii) For children three years of age and older, testing for visual acuity is to be performed and repeated at each examination and must include a distant visual acuity test, which can be performed using the Snellen letter or Symbol E chart. The use of alternative tests (HOTV or Matching Symbol, Faye Symbol, Allen Pictures) should be considered for those preschoolers who cannot be tested by the Snellen letter or Symbol E chart.

(iii) If a child wears eyeglasses, an assessment regarding the need for optometric reevaluation should be made based on screening the child with eyeglasses and the length of time since the last optometric evaluation.

(6) Hearing testing. (i) For children less than three years of age, infant hearing should be tested grossly by the use of loud noises. Deafness must be seriously suspected if there is a delay in development in speech in the older infant.

(ii) For children three years of age and older, testing which consists of a manually administered, individual, pure-tone conduction screening procedure should be provided at each examination.

(iii) In all instances when hearing impairment is suspected by the medical provider based upon testing or an evaluation of the child's risk of hearing impairment, a prompt referral to an approved speech and hearing center must be made.

(7) Assessment of immunization status and provision of immunizations.

(i) An assessment of the record of immunizations given in the past for diphtheria, pertussis, tetanus, polio, rubella, measles and mumps must be recorded. If the dates of the child's previous immunizations are available, they should be recorded in the child's medical chart. If the immunization history is based on parents' reports, efforts to verify this information must be made. Such efforts must be recorded.

(ii) Persons eligible for C/THP services should be immunized in accordance with the following schedules:

(a) Schedule for children beginning immunization in infancy.

<i>Age</i>	<i>Vaccines</i>	<i>Comments</i>
2 months	DTP TOPV	DTP = diphtheria, tetanus, pertussis. TOPV = trivalent oral polio vaccine.
4 months	DTP, TOPV	
6 months	DTP	An optional dose of TOPV may be given.
15 months	Measles Mumps Rubella	One dose of combined measles/mumps/rubella (MMR) vaccine is preferred; a tuberculin skin test may be administered at the same visit.
18 months	DTP TOPV Hib	Hib = Haemophilus influenzae type b disease. Immunization of children at 18 months may be considered in known high-risk groups.

24 months	Hib	Hib immunization of all children is recommended at this age.
4-6 years (school entry)	DTP TOPV	While often referred to as "boosters" these doses constitute an essential part of the immunization process.
14-16 years	Td	Td = Tetanus and diphtheria for adults; repeat every 10 years.

(b) Schedules for children not immunized as infants.

(1) Age 13 months through 6 years.

<i>Visit</i>	<i>Vaccines</i>	<i>Comments</i>
1	DTP TOPV	MMR may be substituted; see comment for visit 2.
		One-month interval between visits.
2	Measles Mumps Rubella	MMR should be given at first visit when risk of exposure is high; DTP and TOPV may then be started at second visit and interval between visits 2 and 3 extended to two months.
		One-month interval between visits.
3	DTP, TOPV	
		Two-month interval between visits.
4	DTP	An optional dose of TOPV may also be given.
		6- to 12-month interval between visits.
5	DTP TOPV	Interval between visits 4 and 5 may be extended (e.g., school entry), but not shortened.
		10-year interval between visits.
6	Td	Repeat every 10 years.

The Hib vaccine can be provided any time from 24 months up to five years of age.

(2) Ages 7 years through 20 years.

<i>Visit</i>	<i>Vaccines</i>	<i>Comments</i>
1	Measles Mumps Rubella*	One dose of Td and one dose of TOPV may also be given at this visit if circumstances warrant (see simultaneous administration of vaccines).
One-month interval between visits.		
2	Td TOPV**	This visit may be eliminated if first doses of Td and TOPV are given at visit 1.
Two-month interval between visits.		
3	Td TOPV**	If visit 2 is eliminated, the interval between visits 1 and 3 must be at least two months.
6- to 12-month interval between visits.		
4	Td TOPV**	Interval between doses 3 and 4 may be extended but not shortened.
10-year interval between visits.		
5	Td	Repeat every 10 years.
<i>Age</i>	<i>Vaccines</i>	<i>Comments</i>
2 months	DTP TOPV	DTP = diphtheria, tetanus, pertussis. TOPV = trivalent oral polio vaccine.
4 months	DTP, TOPV	
6 months	DTP	An optional dose of TOPV may be given.
15 months	Measles Mumps Rubella	One dose of combined measles/mumps/rubella (MMR) vaccine is preferred; a tuberculin skin test may be administered at the same visit.
18 months	DTP TOPV Hib	Hib = Haemophilus influenzae type b disease. Immunization of children at 18 months may be considered in known high-risk groups.
24 months	Hib	Hib immunization of all children is recommended at this age.
4-6 years (school entry)	DTP TOPV	While often referred to as "boosters" these doses constitute an essential part of the immunization process.





(ii) If the phenylketonuria (PKU) test was not performed at birth, because, for example, the baby was born out-of-state, the PKU test should be performed at the first C/THP exam (within one month).

(iii) Sickle cell screening. Those who are at risk of sickle cell disease must receive sickle cell screening. If the clinician makes the judgment that the child is not at risk (by ethnicity or previous screening), a statement of the assessment should appear in the child's medical record. Children born in hospitals within New York State after 1975 are assumed to be adequately screened for sickle cell disease. If the child is at risk of sickle cell disease and there is any doubt about previous testing, sickle cell screening should be provided as part of the exam.

(iv) Anemia screening. A test for anemia must be done at age 9-10 months, 23-25 months, 3 years, 4 years, 5 years, 6 years, and repeated routinely at each age interval as set forth in subdivision (f) of this section. High-risk infants under nine months should also be tested. Where the child's histories indicate a higher risk, the test should be administered more frequently.

(v) Lead screening. Lead screening must be performed routinely on all children aged nine months through five years and at other times judged appropriate by the provider. Education for the prevention of lead poisoning should be directed toward the parent at the time the child is first screened and at subsequent visits.

(vi) Venereal disease screening. Adolescents aged 13 years and older must be assessed for the need for serological screening for syphilis, and all sexually active females should be offered a routine gynecological examination, pap smear, gonococcal culture and counseling regarding the prevention of unplanned pregnancies. If the provider is not properly equipped to perform these services, referral to a gynecologist, family planning or obstetrical/gynecological clinic is recommended.

(9) Urine screening. A urinalysis must be performed at age three years and repeated at each age interval set forth in subdivision (f) of this section.

(10) Dental care assessment. All children up to age three should have their mouths examined at each medical evaluation and, where appropriate, should be referred for dental care. All children aged three years and over should be referred to a dentist or a dental program for diagnostic evaluation and necessary treatment, unless the child has been to a dentist in compliance with the C/THP examination schedule as set forth in subdivision (f) of this section.

(11) Diagnosis and treatment follow-up. A summary diagnosis and plan for treatment or referral and follow-up must be recorded in each child's medical record. Diagnostic and treatment services must be given at the time of the C/THP examination, if appropriate. If a finding requires more extensive diagnosis and/or treatment than is immediately available, an appointment for these services must be scheduled within 60 days of the C/THP examination. The referring physician or clinic is responsible for follow-up, and results of the diagnostic evaluation should be documented in the medical records.

(12) Observation for child abuse and neglect. Suspected cases of child abuse and maltreatment must be reported to the New York State Central Register of Child Abuse and Maltreatment pursuant to the provisions of section 413 of the Social Services Law.

(c) Continuity of care. The C/THP provider should be available not only for initial and periodic C/THP examinations, but also for illness-related services.

(d) Consultation. Consultation with other medical providers should be obtained when deemed necessary by the C/THP provider.

(e) Referral for further diagnosis and/or treatment. When a C/THP examination reveals abnormal conditions and follow-up care is deemed necessary by the C/THP provider, such care must be provided or arranged. Referral to appropriate providers must be made for services which the C/THP provider does not provide. Identification of a condition requiring further diagnosis or treatment during a C/THP examination must be indicated by completion of the CHAP referral code on the claim form submitted for payment.

(f) The following periodicity schedule will apply to all C/THP examinations: (1) 0-1 year--within 1 month; 2-3 months; 4-5 months; 6-7 months; 9-10 months.

(2) 1-6 years--12-13 months; 14-15 months; 16-19 months; 23-24 months; 3 years; 4 years; 5 years.

(3) 6-21 years--6 years; 8-9 years; 10-11 years; 12-13 years; 14-15 years; 16-17 years; 18-19 years; 20 years.

(g) Nonscheduled examination. When a C/THP examination is requested for a child at an age which does not appear on the periodicity schedule contained in subdivision (f) of this section, the provider should, at a minimum, perform those components of the C/THP examination which are required by the last periodic examination the child should have received.

(h) Incomplete required examination. Submission of a claim for a C/THP examination assumes that the provider has taken responsibility to assure that the examination was complete. If the provider cannot complete a recommended component of the examination at the time of the initial examination, every effort should be made to complete the examination at a date determined to be appropriate by the provider.

### **508.9 Coordination with related programs.**

Each local social services district must access other related programs, such as those funded under titles V and XX of the Social Security Act, title X of the Public Health Service Act and head-start programs authorized by the Community Services and Partnership Act of 1974 (P.L. 93-644) to ensure an effective child health program.

### **508.10 Forms and reports.**

(a) Local social services officials and/or providers must, in reporting services provided, claiming reimbursement for the services provided, tracking the services provided and verifying receipt of services, use forms and reports approved by the department.

(b) The department will issue to each social services district a semiannual outreach report that lists persons eligible for C/THP services residing in that district who are identified as requiring the offer of C/THP services. Local social services officials must report on a semiannual outreach report form the results of contacts with persons eligible for C/THP services identified on the semiannual outreach report. Such form must be submitted to the department in accordance with instructions issued by the department.

(c) Local social services officials should use the C/THP exam and referrals report prepared by the department to update C/THP histories of C/THP recipients, to assist in conducting C/THP interviews and to determine the success of outreach activities.

#### **508.11 Payment.**

(a) Examinations performed in accordance with section 508.8 of this Part by providers who are certified under article 28 of the Public Health Law will be reimbursed at the clinic rate established pursuant to such article. Reimbursement will be based upon a complete examination performed according to the periodicity schedule. The appropriate rate code identifying the C/THP examination must be used on the claim form. Clinics billing for C/THP examinations should use specialty code 908 and rate code 3110R on claims submitted to the department.

(b) Except for examinations covered under subdivision (a) of this section, the reimbursable fees for services performed under the C/THP will be those established by the State Department of Health and approved by the Division of the Budget. The C/THP fee for a private physician will be based upon a complete physical examination performed according to the periodicity schedule. Services performed during a C/THP examination or as a follow-up to that examination which are not part of the examination fee, such as immunizations, urinalysis, and pure-tone conduction screening, are eligible for separate reimbursement on a fee-for-service basis. These services should be billed on the same claim form as the C/THP examination. In addition to the C/THP examination, children are eligible to receive all the care and services available under the State medical assistance program. However, only visits rendered in accordance with the recommended C/THP periodicity schedule can be billed as a C/THP exam.

(c) If the child is brought back to complete a component of the examination, a second visit fee or rate cannot be claimed for reimbursement under the medical assistance program. Providers certified pursuant to the provisions of article 28 of the Public Health Law cannot claim an additional fee to complete a component of the previous C/THP examination, regardless of the date of service. However, private physicians are eligible to seek reimbursement for ancillary services (e.g., Mantoux test, immunizations) on a fee-for-service basis, regardless of date of service.

#### **508.12 Continuing care providers.**

(a) Continuing care providers must provide at least the following services to persons eligible for C/THP services formally enrolled with the provider:

(1) screening, diagnosis and treatment, and follow-up services in accordance with C/THP standards contained in section 508.8 of this Part;

(2) maintenance of a comprehensive health history, including information received from other medical or dental providers;

(3) direct provision of, or referral for, medically necessary services;

(4) direct provision of, or referral for, dental services, or referral to the local social services district for such services;

(5) assistance with transportation and/or scheduling assistance for medical or dental services, or referral to the local social services district for such services; and

(6) physician's services as needed by the recipient for acute, episodic or chronic illnesses or conditions.

(b) The agreement with the continuing care provider must specify:

(1) whether direct dental services or referral to dental services are provided. If the provider does not provide either service, then the provider must refer recipients to the local social services district for dental services;

(2) whether transportation to C/THP providers and/or assistance with the scheduling of appointments with C/THP providers will be furnished. If the provider does not furnish either service, the provider must refer recipients to the local social services district for such services; and

(3) that such provider will submit such reports to the department as are agreed to be submitted.

(c) To be formally enrolled with a continuing care provider, a person eligible for C/THP services or person legally responsible for such an eligible person must agree to use one continuing care provider as his/her regular source for the services described in subdivision (a) of this section for a specified period of time. Both the person eligible for C/THP services and the continuing care provider must agree in writing to their respective obligations under a continuing care arrangement.

(d) All agreements between local services districts and health-care maintenance organizations or other continuing care providers must require such organizations and providers to provide the services identified in this section and to comply with the requirements of this section. All such agreements must be approved by the department.



## Family Court Act, Article 6

### **\*§ 657. Certain provisions relating to the guardianship and custody of children by persons who are not the parents of such children..**

(a) Notwithstanding any provision of the law to the contrary, a person possessing a lawful order of guardianship or custody of a minor child, who is not the parent of such child, may enroll such child in public school in the applicable school district where he or she and such child reside. Upon application for enrollment of a minor child by a guardian or custodian who is not the parent of such child, a public school shall enroll such child for such time as the child resides with the guardian or custodian in the applicable school district, upon verification that the guardian or custodian possess a lawful order of guardianship or custody for such child and that the guardian or custodian and the child properly reside in the same household within the school district.

(b) Notwithstanding any provision of the law to the contrary, persons possessing a lawful order of custody of a child who are not a parent of such child shall have the same right to enroll and receive coverage for such child in their employer based health insurance plan and to assert the same legal rights under such employer based health insurance plans as persons who possess lawful orders of guardianship of the person for a child pursuant to rule twelve hundred ten of the civil practices laws and rules, article seventeen on the surrogate's court procedure act, or part 4 of this article.

*\* NB Effective November 3, 2008*

### **\*§ 661. Jurisdiction.**

When initiated in the family court, such court has like jurisdiction and authority to determine as county and surrogates courts in proceedings regarding the guardianship of the person of a minor or infant and permanent guardianship of a child. Such jurisdiction shall apply as follows:

(a) Guardianship of the person of a minor or infant. When making a determination regarding the guardianship of the person of a minor or infant, the provisions of the surrogate's court procedure act shall apply to the extent they are applicable to guardianship of the person of a minor or infant and do not conflict with the specific provisions of this act. For purposes of appointment of a guardian of the person pursuant to this part, the terms infant or minor shall include a person who is less than twenty-one years old who consents to the appointment or continuation of a guardian after the age of eighteen.

(b) Permanent guardianship of a child. Where the guardianship and custody of a child have been committed to an authorized agency pursuant to section six hundred fourteen of this article, or section three hundred eighty-three-c, section three hundred eighty-four or section three hundred eighty-four-b of the social services law, or where both parents of a child whose consent to the adoption of the child would have been required pursuant to section one hundred eleven of the domestic relations law or who were entitled to notice of an adoption proceeding pursuant to section one hundred eleven-a of the domestic relations law are dead, the court may appoint a permanent guardian of a child if the court finds that such appointment is in the best interests of the child. The provisions of the surrogate's court procedure act shall apply to the extent that they are applicable to a proceeding for appointment of a permanent guardian of a child and do not conflict with the specific provisions of this act. Such permanent guardian of a child shall have the right and responsibility to make decisions, including issuing any necessary consents, regarding the child's protection, education, care and control, health and medical needs, and the physical custody of the person of the child, and may consent to the adoption of the child. Provided, however, that nothing in this subdivision shall be construed to limit the ability of a child to consent to his or her own medical care as may be otherwise provided by law.

*\* NB Effective November 3, 2008*



## **Mental Hygiene Law, Title D, Article 22, Section 22.11**

### **§ 22.11 Treatment of minors. [Chemical dependence]**

(a) For the purposes of this section, the word "minor" shall mean a person under eighteen years of age, but does not include a person who is the parent of a child or has married or who is emancipated.

(b) In treating a minor for chemical dependence on an inpatient, residential, or outpatient basis, the important role of the parents or guardians shall be recognized. Steps shall be taken to involve the parents or guardians in the course of treatment, and consent from such a person for inpatient, residential, or outpatient treatment for minors shall be required, except as otherwise provided by subdivision (c) of this section.

(c) Minors admitted for inpatient, residential or outpatient treatment without parental or guardian involvement.

1. If, in the judgment of a physician, parental or guardian involvement and consent would have a detrimental effect on the course of treatment of a minor who is voluntarily seeking treatment for chemical dependence or if a parent or guardian refuses to consent to such treatment and the physician believes that such treatment is necessary for the best interests of the child, such treatment may be provided to the minor by a licensed physician on an inpatient, residential or outpatient basis, a staff physician in a hospital, or persons operating under their supervision, without the consent or involvement of the parent or guardian. Such physician shall fully document the reasons why the requirements of subdivision (b) of this section were dispensed within the minor's medical record, provided, however, that for providers of services which are not required to include physicians on staff, pursuant to regulations promulgated by the commissioner, a qualified health professional, as defined in such regulations, shall fulfill the role of a physician for purposes of this paragraph.

2. If the provider of services cannot locate the parents or guardians of a minor seeking treatment for chemical dependence after employing reasonable measures to do so, or if such parents or guardians refuse or fail to communicate with the provider of services within a reasonable time regarding the minor's treatment, the program director may authorize that such minor be treated on an inpatient, residential or outpatient basis by the provider of services without the consent or involvement of the parent or guardian. Such program director shall fully document the reasons why the requirements of subdivision (b) of this section were dispensed within the minor's medical record, including an explanation of all efforts employed to attempt to contact such parents or guardians.

3. Admission and discharge for inpatient or residential treatment shall be made in accordance with subdivision (d) of this section.

(d) Inpatient or residential treatment. 1. Admission procedures.

(i) A copy of the patient's rights established under this section and under section 22.03 of this article shall be given and explained to the minor and to the minor's consenting parent or guardian at the time of admission by the director of the facility or such person's designee.

(ii) The minor shall be required to sign a form indicating that the treatment is being voluntarily sought, and that he or she has been advised of his or her ability to access the mental hygiene legal service and of his or her rights under this section and section 22.03 of this article. The signed form shall be included in the minor's medical record.

(iii) At the time of admission, any minor so admitted shall be informed by the director of the facility or the director's designee, orally and in writing, of the minor's right to be discharged in accordance with the provisions of this section within twenty-four hours of his or her making a request therefor.

(iv) Emergency contacts.

(A) At the time of admission, the provider of services shall use its best efforts to obtain from the minor's consenting parent or guardian a telephone number or numbers where he or she may be reached by the facility at any time during the day or night. In addition, such provider of services shall also use its best efforts to obtain from the parent or guardian a name, address and appropriate telephone number or

numbers of an adult designated by such parent or guardian as an emergency contact person in the event the facility is unable to reach such parent or guardian.

(B) If the minor is admitted in accordance with subdivision (c) of this section, the provider of services shall use its best efforts to obtain from the minor the name, address, and telephone number of an adult who may serve as an emergency contact, and the facility shall verify the existence and availability of such contact upon notice to and with the prior written consent of the minor.

(C) Failure to obtain emergency contacts, after reasonable effort, in accordance with this section shall not preclude admission of the minor to treatment.

(v) Notice of admission and discharge procedures.

(A) A copy of the facility's admission and discharge procedures shall be provided to the minor and to the minor's consenting parent or guardian at the time of admission by the director of the facility or such person's designee. Such information shall also be mailed to the designated emergency contact person by regular mail.

(B) If the minor is admitted in accordance with subdivision (c) of this section, a copy of the facility's admission and discharge procedures shall be provided to the minor. Such information shall also be mailed to the designated emergency contact person by regular mail.

(vi) Each minor admitted for inpatient or residential chemical dependence treatment pursuant to this subdivision shall be provided with written notice regarding the availability of the mental hygiene legal service for legal counsel, and shall be provided access to the service upon request.

2. Discharge procedures. All minors admitted pursuant to this subdivision shall be discharged in accordance with the following:

(i) Any minor admitted to an inpatient or residential chemical dependence treatment facility has the right to be discharged within twenty-four hours of his or her request in accordance with the provisions of this subdivision.

(ii) If discharge is requested prior to completion of a minor's treatment plan, such minor must request discharge in writing.

(A) Upon receipt of any form of written request for discharge, the director of the facility in which the minor is admitted shall immediately notify the minor's parent or guardian. If the facility is unable to contact such parent or guardian within a reasonable time, or if the minor has been admitted pursuant to subdivision (c) of this section, the facility shall notify the designated emergency contact person.

(B) The minor shall not be discharged from such facility until it is determined:

(1) that the safety and well being of such minor will not be threatened or the expiration of twenty-four hours, whichever is sooner; or

(2) that the parent, guardian, or designated emergency contact person has made appropriate and timely departure arrangements with the facility. However, unless otherwise directed by the minor's parent or guardian or designated emergency contact person pursuant to this item, such minor shall be discharged within twenty-four hours after submission of the request.

(iii) Writing materials for use in requesting a discharge shall be made available at all times to all minors admitted under this section. The staff of the facility shall assist such minors in preparing or submitting requests for discharge.

## **Mental Hygiene Law, Title E, Article 33, Section 33.21**

### **§ 33.21 Consent for mental health treatment of minors.**

(a) For the purposes of this section:

(1) "minor" shall mean a person under eighteen years of age, but shall not include a person who is the parent of a child, emancipated, has married or is on voluntary status on his or her own application pursuant to section 9.13 of this chapter;

(2) "mental health practitioner" shall mean a physician, a licensed psychologist, or persons providing services under the supervision of a physician in a facility operated or licensed by the office of mental health;

(3) "outpatient mental health services" shall mean those services provided in an outpatient program licensed or operated pursuant to the regulations of the commissioner of mental health;

(4) "reasonably available" shall mean a parent or guardian can be contacted with diligent efforts by a mental health practitioner; and

(5) "capacity" shall mean the minor's ability to understand and appreciate the nature and consequences of the proposed treatment, including the benefits and risks of, and alternatives to, such proposed treatment, and to reach an informed decision.

(b) In providing outpatient mental health services to a minor, or psychotropic medications to a minor residing in a hospital, the important role of the parents or guardians shall be recognized. As clinically appropriate, steps shall be taken to actively involve the parents or guardians, and the consent of such persons shall be required for such treatment in non-emergency situations, except as provided in subdivisions (c), (d) and (e) of this section or section two thousand five hundred four of the public health law.

(c) A mental health practitioner may provide outpatient mental health services, other than those treatments and procedures for which consent is specifically required by section 33.03 of this article, to a minor voluntarily seeking such services without parental or guardian consent if the mental health practitioner determines that:

(1) the minor is knowingly and voluntarily seeking such services; and

(2) provision of such services is clinically indicated and necessary to the minor's well-being; and

(3) (i) a parent or guardian is not reasonably available; or

(ii) requiring parental or guardian consent or involvement would have a detrimental effect on the course of outpatient treatment; or

(iii) a parent or guardian has refused to give such consent and a physician determines that treatment is necessary and in the best interests of the minor.

The mental health practitioner shall fully document the reasons for his or her determinations. Such documentation shall be included in the minor's clinical record, along with a written statement signed by the minor indicating that he or she is voluntarily seeking services. As clinically appropriate, notice of a determination made pursuant to subparagraph (iii) of paragraph three of this subdivision shall be provided to the parent or guardian.

(d) A mental health practitioner may provide a minor voluntarily seeking outpatient services an initial interview without parental or guardian consent or involvement to determine whether the criteria of subdivision (c) of this section are present.

(e) (1) Subject to the regulations of the commissioner of mental health governing the patient's right to object to treatment, subdivision (b) of this section and paragraph two of this subdivision, the consent of a parent or guardian or the authorization of a court shall be required for the non-emergency administration of psychotropic medications to a minor residing in a hospital.

(2) A minor sixteen years of age or older who consents may be administered psychotropic medications without the consent of a parent or guardian or the authorization of a court where:

(i) a parent or guardian is not reasonably available, provided the treating physician determines that (A) the minor has capacity; and (B) such medications are in the minor's best interests; or

(ii) requiring consent of a parent or guardian would have a detrimental effect on the minor, provided the treating physician and a second physician who specializes in psychiatry and is not an employee of the hospital determine that (A) such detrimental effect would occur; (B) the minor has capacity; and (C) such medications are in the minor`s best interests; or

(iii) the parent or guardian has refused to give such consent, provided the treating physician and a second physician who specializes in psychiatry and is not an employee of the hospital determine that (A) the minor has capacity; and (B) such medications are in the minor`s best interests. Notice of the decision to administer psychotropic medications pursuant to this subparagraph shall be provided to the parent or guardian.

(3) The reasons for an exception authorized pursuant to paragraph two of this subdivision shall be fully documented and such documentation shall be included in the minor`s clinical record.

**Public Health Law, Article 1, Title 2, Section 17**

**§ 17. Release of medical records.** Upon the written request of any competent patient, parent or guardian of an infant, a guardian appointed pursuant to article eighty-one of the mental hygiene law, or conservator of a conservatee, an examining, consulting or treating physician or hospital must release and deliver, exclusive of personal notes of the said physician or hospital, copies of all x-rays, medical records and test records including all laboratory tests regarding that patient to any other designated physician or hospital provided, however, that such records concerning the treatment of an infant patient for venereal disease or the performance of an abortion operation upon such infant patient shall not be released or in any manner be made available to the parent or guardian of such infant, and provided, further, that original mammograms, rather than copies thereof, shall be released and delivered. Either the physician or hospital incurring the expense of providing copies of x-rays, medical records and test records including all laboratory tests pursuant to the provisions of this section may impose a reasonable charge to be paid by the person requesting the release and deliverance of such records as reimbursement for such expenses, provided, however, that the physician or hospital may not impose a charge for copying an original mammogram when the original has been released or delivered to any competent patient, parent or guardian of an infant, a guardian appointed pursuant to article eighty-one of the mental hygiene law, or a conservator of a conservatee and provided, further, that any charge for delivering an original mammogram pursuant to this section shall not exceed the documented costs associated therewith. However, the reasonable charge for paper copies shall not exceed seventy-five cents per page. A release of records under this section shall not be denied solely because of inability to pay. For the purposes of this section the term "laboratory tests" shall include but not be limited to tests and examinations administered in clinical laboratories or blood banks as those terms are defined in section five hundred seventy-one of this chapter.



## Public Health Law, Article 21, Title 6, Section 2168

### § 2168. Statewide immunization registry.

1. The department is hereby directed to establish a statewide automated and electronic immunization registry that will serve, and shall be administered consistent with, the following public health purposes:

(a) collect reports of immunizations and thus reduce the incidence of illness, disability and death due to vaccine preventable diseases;

(b) establish the public health infrastructure necessary to obtain, collect, preserve, and disclose information relating to vaccine preventable disease as it may promote the health and well-being of all children in this state;

(c) make available to an individual, or parents, guardians, or other person in a custodial relation to a child or, to local health districts, local social services districts responsible for the care and custody of children, health care providers and their designees, schools, and third party payers the immunization status of children; and

(d) appropriately protecting the confidentiality of individual identifying information and the privacy of persons included in the registry and their families.

2. For the purposes of this section:

(a) The term "authorized user" shall mean any person or entity authorized to provide information to or to receive information from the immunization registry and shall include health care providers and their designees, as defined in paragraph (d) of this subdivision, schools as defined in paragraph a of subdivision one of section twenty-one hundred sixty-four of this title, health maintenance organizations certified under article forty-four of this chapter or article forty-three of the insurance law, local health districts as defined by paragraph (c) of subdivision one of section two of this chapter, and local social services districts and the office of children and family services with regard to children in their legal custody. An authorized user may be located outside New York state. An entity other than a local health district shall be an authorized user only with respect to a person seeking or receiving a health care service from the health care provider, a person enrolled or seeking to be enrolled in the school, a person insured by the health maintenance organization, or a person in the custody of the local social services district or the office of children and family services, as the case may be.

(b) The term "immunization registry" shall mean a statewide-computerized database maintained by the department capable of collecting, storing, and disclosing the electronic and paper records of vaccinations received by persons under nineteen years of age.

(c) The term "citywide immunization registry" shall mean the computerized database maintained by the city of New York department of health and mental hygiene capable of collecting, storing, and disclosing the electronic and paper records of vaccinations received by persons under nineteen years of age. For the purposes of this section the term New York city department of health and mental hygiene shall mean such agency or any successor agency responsible for the citywide immunization registry.

(d) The term "health care provider" shall mean any person authorized by law to order or administer an immunization or any health care facility licensed under article twenty-eight of this chapter or any certified home health agency established under section thirty-six hundred six of this chapter; with respect to a person seeking or receiving a health care service from the health care provider.

(e) For purposes of this section a school is a public health authority, as defined in section 164.501 of part 45 of the federal code of rules, responsible for screening the immunization status of each child pursuant to section twenty-one hundred sixty-four of this article.

3. (a) Any health care provider who administers any vaccine to a person under nineteen years of age; and immunizations received by a person under nineteen years of age in the past if not already reported, shall report all such immunizations to the department in a format prescribed by the commissioner within fourteen days of administration. Health care providers administering immunizations to persons under

nineteen years of age in the city of New York shall report, in a format prescribed by the city of New York commissioner of health and mental hygiene, all such immunizations to the citywide immunization registry. The commissioner, and for the city of New York the commissioner of health and mental hygiene, shall have the discretion to accept for inclusion in the registry information regarding immunizations administered to individuals nineteen years of age or older with the express written consent of the vaccinee [sic].

(b) The immunization registry shall provide a method for health care providers to determine when the registrant is due or late for a recommended immunization and shall serve as a means for authorized users to receive prompt and accurate information, as reported to the registry, about the vaccines that the registrant has received.

4. (a) All information maintained by the department, or in the case of the citywide immunization registry, the city of New York under the provisions of this section shall be confidential except as necessary to carry out the provisions of this section and shall not be released for any other purpose.

(b) The department and for the city of New York the department of health and mental hygiene may also disclose or provide such information to an authorized user when (i) such person or agency provides sufficient identifying information satisfactory to the department to identify such registrant and (ii) such disclosure or provision of information is in the best interests of the registrant or his or her family, or will contribute to the protection of the public health.

(c) Any data collected by the department may be included in the immunization registry if collection, storage and access of such data is otherwise authorized. Such data may be disclosed to the immunization registry only if provided for in statute and regulation, and shall be subject to any provisions in such statute or regulation limiting the use or redisclosure of the data. Nothing contained in this paragraph shall permit inclusion of data in the immunization registry if that data could not otherwise be accessed or disclosed in the absence of the registry. For the city of New York the commissioner of health and mental hygiene may include data collected in the citywide registry as provided in this paragraph.

(d) A person, institution or agency to whom such immunization registry information is furnished or to whom, access to records or information has been given, shall not divulge any part thereof so as to disclose the identity of such person to whom such information or record relates, except insofar as such disclosure is necessary for the best interests of the person or other persons, consistent with the purposes of this section.

5. (a) All health care providers and their designees, except for providers reporting to the citywide immunization registry, shall submit to the commissioner information about any vaccinee under nineteen years of age and about each vaccination given after January first, two thousand eight. The information provided to the registry or the citywide immunization registry shall include the national immunization program data elements and other elements required by the commissioner. For the city of New York the commissioner of health and mental hygiene may require additional elements with prior notice to the commissioner of any changes.

(b) In addition to the immunization administration information required by this section, the operation of any immunization registry established under chapter five hundred twenty-one of the laws of nineteen hundred ninety-four, section 11.04 of title twenty-four of volume eight of the compilation of the rules of the city of New York and administered by a local health district collecting information from health care providers about vaccinations previously administered to a vaccinee prior to the effective date of this section shall provide the commissioner access to such information.

(c) All health care providers shall provide the department or, as appropriate, the city of New York with additional or clarifying information upon request reasonably related to the purposes of this section.

(d) Notwithstanding the above, submission of incomplete information shall not prohibit entry of incomplete but viable data into the registry database.

(e) The commissioner of the department of health and mental hygiene for the city of New York shall implement the requirements of this subdivision.

(f) The immunization status of children exempt from immunizations pursuant to subdivision eight and a parent claiming exemption pursuant to subdivision nine of section twenty-one hundred sixty-four of this title shall be reported by the health care provider.

6. In the city of New York, the commissioner of the department of health and mental hygiene of the city of New York may maintain its existing registry consistent with the requirements of this section and shall provide information to the commissioner and to authorized users.

7. Each parent or legal guardian of a newborn infant or a child newly enrolled in the registry shall receive information, developed by the department, describing the registry enrollment process and how to review and correct information and obtain a copy of the child's immunization record. The city of New York will be responsible for providing information about the processes for enrollment and access to the citywide immunization registry by a parent or legal guardian of a newborn infant or newly enrolled child residing in the city of New York.

8. Access and use of identifiable registrant information shall be limited to authorized users consistent with this subdivision and the purposes of this section.

(a) The commissioner shall provide a method by which authorized users apply for access to the registry. For the city of New York, the commissioner of health and mental hygiene shall provide a method by which authorized users apply for access to the registry.

(b) (i) The commissioner may use the immunization registry for purposes of outreach, quality improvement and vaccine accountability, research, epidemiological studies and disease control; (ii) the commissioner of health and mental hygiene for the city of New York may use the immunization registry for purposes of outreach, quality improvement and vaccine accountability, research, epidemiological studies and disease control; (iii) local health departments shall have access to the immunization registry for purposes of outreach, quality improvement and vaccine accountability, epidemiological studies and disease control within their county; and

(c) health care providers and their designees shall have access to the immunization registry only for purposes of submission of information about vaccinations received by a specific registrant, determination of the immunization status of a specific registrant, review of practice coverage, generation of reminder notices, quality improvement and vaccine accountability and printing a copy of the immunization record for the registrant's medical record, for the registrant's parent or guardian, or other person in parental or custodial relation to a child, or for a registrant upon reaching eighteen years of age.

(d) The following authorized users shall have access to the immunization registry and the citywide immunization registry for the purposes stated in this paragraph: (i) schools for verifying eligibility for admission; (ii) health maintenance organizations for performing quality assurance, accountability and outreach, relating to enrollees covered by the health maintenance organization; (iii) commissioners of local social services districts with regard to a child in his/her legal custody; and (iv) the commissioner of the office of children and family services with regard to children in their legal custody, and for quality assurance and accountability of commissioners of local social services districts, care and treatment of children in the custody of commissioners of local social services districts.

9. The commissioner may judge the legitimacy of any request for immunization registry information and may refuse access to the immunization registry based on the authenticity of the request, credibility of the authorized user or other reasons as provided for in regulation. For the city of New York the commissioner of health and mental hygiene may judge the legitimacy of requests for access to the citywide immunization registry and refuse access to the immunization registry based on the authenticity of the request, credibility of the authorized user or other reasons as provided for in regulation.

10. The person to whom any immunization record relates, or his or her parent, or guardian, or other person in parental or custodial relation to such person may request a copy of an immunization record from

the registrant's healthcare provider, the immunization registry or the citywide immunization registry according to procedures established by the commissioner or, in the case of the citywide immunization registry, by the city of New York commissioner of the department of health and mental hygiene.

11. The commissioner may provide registrant specific immunization records to other state registries pursuant to a written agreement requiring that the foreign registry conform to national standards for maintaining the integrity of the data and will not be used for purposes inconsistent with the provisions of this section.

12. Information that would be provided upon the enrollment in the registry of a child being vaccinated, from birth records of all infants born in New York state on or after January first, two thousand four shall be entered into the immunization registry, except in the city of New York, where birth record information shall be entered into the citywide immunization registry.

13. The commissioner shall promulgate regulations as necessary to effectuate the provisions of this section. Such regulations shall include provision for orderly implementation and operation of the registry, including the method by which each category of authorized user may access the registry. Access standards shall include at a minimum a method for assigning and authenticating each user identification and password assigned.

14. No authorized user shall be subjected to civil or criminal liability, or be deemed to have engaged in unprofessional conduct for reporting to, receiving from, or disclosing information relating to the registry when made reasonably and in good faith and in accordance with the provisions of this section or any regulation adopted thereto.

## **Public Health Law, Article 23, Title 1, Section 2305**

### **§ 2305. Sexually transmissible diseases; treatment by licensed physician or staff physician of a hospital; prescriptions.**

1. No person, other than a licensed physician, or, in a hospital, a staff physician, shall diagnose, treat or prescribe for a person who is infected with a sexually transmissible disease, or who has been exposed to infection with a sexually transmissible disease, or dispense or sell a drug, medicine or remedy for the treatment of such person except on prescription of a duly licensed physician.

2. A licensed physician, or in a hospital, a staff physician, may diagnose, treat or prescribe for a person under the age of twenty-one years without the consent or knowledge of the parents or guardian of said person, where such person is infected with a sexually transmissible disease, or has been exposed to infection with a sexually transmissible disease.

3. For the purposes of this section, the term "hospital" shall mean a hospital as defined in article twenty-eight of this chapter.

## **Public Health Law, Article 25, Title 1, Section 2504**

### **§ 2504. Enabling certain persons to consent for certain medical, dental, health and hospital services.**

1. Any person who is eighteen years of age or older, or is the parent of a child or has married, may give effective consent for medical, dental, health and hospital services for himself or herself, and the consent of no other person shall be necessary.

2. Any person who has been married or who has borne a child may give effective consent for medical, dental, health and hospital services for his or her child.

3. Any person who is pregnant may give effective consent for medical, dental, health and hospital services relating to prenatal care.

4. Medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when, in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health.

5. Where not otherwise already authorized by law to do so, any person in a parental relation to a child as defined in section twenty-one hundred sixty-four of this chapter and, (i) a grandparent, an adult brother or sister, an adult aunt or uncle, any of whom has assumed care of the child and, (ii) an adult who has care of the child and has written authorization to consent from a person in a parental relation to a child as defined in section twenty-one hundred sixty-four of this chapter, may give effective consent for the immunization of a child. However, a person other than one in a parental relation to the child shall not give consent under this subdivision if he or she has reason to believe that a person in parental relation to the child as defined in section twenty-one hundred sixty-four of this chapter objects to the immunization.

6. Anyone who acts in good faith based on the representation by a person that he is eligible to consent pursuant to the terms of this section shall be deemed to have received effective consent.



## Public Health Law, Article 27-F

### HIV AND AIDS RELATED INFORMATION

#### Section 2780. Definitions.

- 2781. HIV related testing.
- 2782. Confidentiality and disclosure.
- 2783. Penalties; immunities.
- 2784. Applicability to insurance institutions and insurance support organizations.
- 2785. Court authorization for disclosure of confidential HIV related information.
- 2785-a. Court order for HIV related testing in certain cases.
- 2786. Rules and regulations; forms; report.
- 2787. Separability.

**§ 2780. Definitions.** As used in this article, the following terms shall have the following meanings:

1. "AIDS" means acquired immune deficiency syndrome, as may be defined from time to time by the centers for disease control of the United States public health service.
2. "HIV infection" means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS.
3. "HIV related illness" means any illness that may result from or may be associated with HIV infection.
4. "HIV related test" means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or to indicate the presence of AIDS.
5. "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 concerning the service, treatment, procedure or disclosure.
6. "Protected individual" means a person who is the subject of an HIV related test or who has been diagnosed as having HIV infection, AIDS or HIV related illness.
7. "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 of such conditions, including information pertaining to such individual's contacts.
8. "Health or social service" means any public or private care, treatment, clinical laboratory test, counseling or educational service for adults or children, and acute, chronic, custodial, residential, outpatient, home or other health care provided pursuant to this chapter or the social services law; public assistance or care as defined in article one of the social services law; employment-related services, housing services, foster care, shelter, protective services, day care, or preventive services provided pursuant to the social services law; services for the mentally disabled as defined in article one of the mental hygiene law; probation services, provided pursuant to articles twelve and twelve-A of the executive law; parole services, provided pursuant to article twelve-B of the executive law; correctional services, provided pursuant to the correction law; detention and rehabilitative services provided pursuant to article nineteen-G of the executive law; and the activities of the health care worker HIV/HBV advisory panel pursuant to article twenty-seven-DD of this chapter.
9. "Release of confidential HIV related information" means a written authorization for disclosure of confidential HIV related information which is signed by the protected individual, or if the protected individual lacks capacity to consent, a person authorized pursuant to law to consent to health care for the individual. Such release shall be dated and shall specify to whom disclosure is authorized, the purpose for such disclosure and the time period during which the release is to be effective. A general authorization for the release of medical or other information shall not be construed as a release of confidential HIV related information, unless such authorization specifically indicates its dual purpose as a general authorization

and an authorization for the release of confidential HIV related information and complies with the requirements of this subdivision.

10. "Contact" means an identified spouse or sex partner of the protected individual, a person identified as having shared hypodermic needles or syringes with the protected individual or a person who the protected individual may have exposed to HIV under circumstances that present a risk of transmission of HIV, as determined by the commissioner.

11. "Person" includes any natural person, partnership, association, joint venture, trust, public or private corporation, or state or local government agency.

12. "Health facility" means a hospital as defined in section two thousand eight hundred one of this chapter, blood bank, blood center, sperm bank, organ or tissue bank, clinical laboratory, or facility providing care or treatment to persons with a mental disability as defined in article one of the mental hygiene law.

13. "Health care provider" means any physician, nurse, provider of services for the mentally disabled as defined in article one of the mental hygiene law, or other person involved in providing medical, nursing, counseling, or other health care or mental health service, including those associated with, or under contract to, a health maintenance organization or medical services plan.

14. "Child" means any protected individual actually or apparently under eighteen years of age.

15. "Authorized agency" means any agency defined by section three hundred seventy-one of the social services law and, for the purposes of this article, shall include such corporations incorporated or organized under the laws of the state as may be specifically authorized by their certificates of incorporation to receive children for the purposes of adoption or foster care.

16. "Insurance institution" means any corporation, association, partnership, reciprocal exchange, interinsurer, fraternal benefits society, agent, broker or other entity including, but not limited to, any health maintenance organization, medical service plan, or hospital plan which: (a) is engaged in the business of insurance; (b) provides health services coverage plans; or (c) provides benefits under, administers, or provides services for, an employee welfare benefit plan as defined in 29 U.S.C. 1002(1).

17. "Insurance support organization" means any person who regularly engages, in whole or in part, in the practice of assembling or collecting information about natural persons for the primary purpose of providing the information to an insurance institution for insurance transactions, including: (a) the furnishing of consumer reports or investigative consumer reports to an insurance institution for use in connection with an insurance transaction; or (b) the collection of personal information from insurance institutions or other insurance support organizations for the purpose of detecting or preventing fraud, material misrepresentation, or material non-disclosure in connection with insurance underwriting or insurance claim activity. The following persons shall not be considered "insurance-support organizations" for the purposes of this article: government institutions, insurance institutions, health facilities and health care providers.

**§ 2781. HIV related testing.** 1. Except as provided in section three thousand one hundred twenty-one of the civil practice law and rules, or unless otherwise specifically authorized or required by a state or federal law, no person shall order the performance of an HIV related test without first receiving the written, informed consent of the subject of the test who has capacity to consent or, when the subject lacks capacity to consent, of a person authorized pursuant to law to consent to health care for such individual. A physician or other person authorized pursuant to law to order the performance of an HIV related test shall certify, in the order for the performance of an HIV related test, that informed consent required by this section has been received prior to ordering such test by a laboratory or other facility.

2. Informed consent to an HIV related test shall consist of a statement signed by the subject of the test who has capacity to consent or, when the subject lacks capacity to consent, by a person authorized pursuant to law to consent to health care for the subject which includes at least the following:

(a) an explanation of the test, including its purpose, the meaning of its results, and the benefits of early diagnosis and medical intervention; and

(b) an explanation of the procedures to be followed, including that the test is voluntary, that consent may be withdrawn at any time, and a statement advising the subject that anonymous testing is available; and

(c) an explanation of the confidentiality protections afforded confidential HIV related information under this article, including the circumstances under which and classes of persons to whom disclosure of such information may be required, authorized or permitted under this article or in accordance with other provisions of law or regulation.

3. Prior to the execution of a written informed consent, a person ordering the performance of an HIV related test shall provide to the subject of an HIV related test or, if the subject lacks capacity to consent, to a person authorized pursuant to law to consent to health care for the subject, an explanation of the nature of AIDS and HIV related illness, information about discrimination problems that disclosure of the test result could cause and legal protections against such discrimination, and information about behavior known to pose risks for transmission and contraction of HIV infection.

4. A person authorized pursuant to law to order the performance of an HIV related test shall provide to the person seeking such test an opportunity to remain anonymous and to provide written, informed consent through use of a coded system with no linking of individual identity to the test request or results. A health care provider who is not authorized by the commissioner to provide HIV related tests on an anonymous basis shall refer a person who requests an anonymous test to a test site which does provide anonymous testing. The provisions of this subdivision shall not apply to a health care provider ordering the performance of an HIV related test on an individual proposed for insurance coverage.

5. At the time of communicating the test result to the subject of the test, a person ordering the performance of an HIV related test shall provide the subject of the test or, if the subject lacks capacity to consent, the person authorized pursuant to law to consent to health care for the subject with counseling or referrals for counseling:

(a) for coping with the emotional consequences of learning the result;

(b) regarding the discrimination problems that disclosure of the result could cause;

(c) for behavior change to prevent transmission or contraction of HIV infection; (d) to inform such person of available medical treatments; and

(e) regarding the test subject's need to notify his or her contacts.

6. The provisions of this section shall not apply to the performance of an HIV related test:

(a) by a health care provider or health facility in relation to the procuring, processing, distributing or use of a human body or a human body part, including organs, tissues, eyes, bones, arteries, blood, semen, or other body fluids, for use in medical research or therapy, or for transplantation to individuals provided, however, that where the test results are communicated to the subject, post-test counseling, as described in subdivision five of this section, shall nonetheless be required; or

(b) for the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher; or

(c) on a deceased person, when such test is conducted to determine the cause of death or for epidemiological purposes.

(d) conducted pursuant to section twenty-five hundred-f of this chapter.

**§ 2782. Confidentiality and disclosure.** 1. No person who obtains confidential HIV related information in the course of providing any health or social service or pursuant to a release of confidential HIV related information may disclose or be compelled to disclose such information, except to the following:

(a) the protected individual or, when the protected individual lacks capacity to consent, a person authorized pursuant to law to consent to health care for the individual;

(b) any person to whom disclosure is authorized pursuant to a release of confidential HIV related information;

(c) an agent or employee of a health facility or health care provider if (1) the agent or employee is permitted to access medical records, (2) the health facility or health care provider itself is authorized to obtain the HIV related information, and (3) the agent or employee provides health care to the protected individual, or maintains or processes medical records for billing or reimbursement;

(d) a health care provider or health facility when knowledge of the HIV related information is necessary to provide appropriate care or treatment to the protected individual, a child of the individual, a contact of the protected individual or a person authorized to consent to health care for such a contact;

(e) a health facility or health care provider, in relation to the procurement, processing, distributing or use of a human body or a human body part, including organs, tissues, eyes, bones, arteries, blood, semen, or other body fluids, for use in medical education, research, therapy, or for transplantation to individuals;

(f) health facility staff committees or accreditation or oversight review organizations authorized to access medical records; provided that such committees or organizations may only disclose confidential HIV related information: (1) back to the facility or provider of a health or social service; (2) to carry out the monitoring, evaluation, or service review for which it was obtained; or (3) to a federal, state or local government agency for the purposes of and subject to the conditions provided in subdivision six of this section;

(g) a federal, state, county or local health officer when such disclosure is mandated by federal or state law;

(h) an authorized agency in connection with foster care or adoption of a child. Such agency shall be authorized to redisclose such information only pursuant to this article or in accordance with the provisions of subdivision eight of section three hundred seventy-two and section three hundred seventy-three-a of the social services law;

(i) third party reimbursers or their agents to the extent necessary to reimburse health care providers for health services; provided that, where necessary, an otherwise appropriate authorization for such disclosure has been secured by the provider;

(j) an insurance institution, for other than the purpose set forth in paragraph (i) of this subdivision, provided the insurance institution secures a dated and written authorization that indicates that health care providers, health facilities, insurance institutions, and other persons are authorized to disclose information about the protected individual, the nature of the information to be disclosed, the purposes for which the information is to be disclosed and which is signed by: (1) the protected individual; (2) if the protected individual lacks the capacity to consent, such other person authorized pursuant to law to consent for such individual; or (3) if the protected individual is deceased, the beneficiary or claimant for benefits under an insurance policy, a health services plan, or an employee welfare benefit plan as defined in 29 U.S.C. 1002(1), covering such protected individual;

(k) any person to whom disclosure is ordered by a court of competent jurisdiction pursuant to section twenty-seven hundred eighty-five of this article;

(l) an employee or agent of the division of parole, in accordance with paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, to the extent the employee or agent is authorized to access records containing such information in order to carry out the division's functions, powers and duties with respect to the protected individual, pursuant to section two hundred fifty-nine-a of the executive law;

(m) an employee or agent of the division of probation and correctional alternatives or any local probation department, in accordance with paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, to the extent the employee or agent is authorized to access records containing such information in order to carry out the division's or department's functions, powers and duties with respect to the protected individual, pursuant to articles twelve and twelve-A of the executive law;

(n) a medical director of a local correctional facility as defined in section forty of the correction law, in accordance with paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, to the extent the medical director is authorized to access records containing such information in order to carry out his or her functions, powers and duties with respect to the protected individual; or

(o) an employee or agent of the commission of correction, in accordance with paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, to the extent the employee or agent is authorized to access records containing such information in order to carry out the commission's

functions, powers and duties with respect to the protected individual, pursuant to article three of the correction law.

(p) a law guardian, appointed to represent a minor pursuant to the social services law or the family court act, with respect to confidential HIV related information relating to the minor and for the purpose of representing the minor. If the minor has the capacity to consent, the law guardian may not redisclose confidential HIV related information without the minor's permission. If the minor lacks capacity to consent, the law guardian may redisclose confidential HIV related information for the sole purpose of representing the minor. This paragraph shall not limit a law guardian's ability to seek relief under section twenty-seven hundred eighty-five of this chapter.

2. A state, county or local health officer may disclose confidential HIV related information when:

- (a) disclosure is specifically authorized or required by federal or state law; or
- (b) disclosure is made pursuant to a release of confidential HIV related information; or
- (c) disclosure is requested by a physician pursuant to subdivision four of this section; or
- (d) disclosure is authorized by court order pursuant to the provisions of section twenty-seven hundred eighty-five of this article.

3. No person to whom confidential HIV related information has been disclosed pursuant to this article shall disclose the information to another person except as authorized by this article, provided, however, that the provisions of this subdivision shall not apply:

- (a) to the protected individual; or
- (b) to a natural person who is authorized pursuant to law to consent to health care for the protected individual; or
- (c) to a protected individual's foster parent as defined in section three hundred seventy-one of the social services law and subject to regulations promulgated pursuant to paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, for the purpose of providing care, treatment or supervision of the protected individual; or
- (d) a prospective adoptive parent as specified in section three hundred seventy-three-a of the social services law and subject to regulations promulgated pursuant to paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article with whom a child who is the protected individual has been placed for adoption; or
- (e) to a relative or other person legally responsible to whom a child who is the protected individual is to be placed or discharged pursuant to section ten hundred seventeen or ten hundred fifty-five of the family court act and subject to regulations promulgated pursuant to paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, for the purpose of providing care, treatment or supervision of the protected individual.

4. (a) A physician may disclose confidential HIV related information under the following conditions:

- (1) disclosure is made to a contact, to a public health officer for the purpose of making the disclosure to said contact and pursuant to section twenty-one hundred thirty of this chapter; or
- (2) the physician believes disclosure is medically appropriate and there is a significant risk of infection to the contact; and
- (3) the physician has counseled the protected individual regarding the need to notify the contact; and
- (4) the physician has informed the protected individual of his or her intent to make such disclosure to a contact, the physician's responsibility to report the infected individual's case pursuant to section twenty-one hundred thirty of this chapter and has given the protected individual the opportunity to express a preference as to whether disclosure should be made by the physician directly or to a public health officer for the purpose of said disclosure. If the protected individual expresses a preference for disclosure by a public health officer, the physician shall honor such preference.

(5) If a physician chooses to make a notification pursuant to this section, he or she shall report to the municipal health commissioner or district health officer on his or her efforts to notify the contacts of the protected individual. Such report shall be in a manner and on forms prescribed by the commissioner and shall include the identity of the protected individual and any contacts as well as information as to whether the contacts were successfully notified.

(6) Within a reasonable time of receiving a report that a physician or his or her designated agent did not notify or verify notification of contacts provided by the protected individual, the health commissioner or district health officer of the municipality from which the report originates shall take reasonable measures to notify such contacts and otherwise comply with the provisions of this chapter.

(b) When making such disclosures to the contact, the physician or public health officer shall provide or make referrals for the provision of the appropriate medical advice and counseling for coping with the emotional consequences of learning the information and for changing behavior to prevent transmission or contraction of HIV infection. The physician or public health officer shall not disclose the identity of the protected individual or the identity of any other contact. A physician or public health officer making a notification pursuant to this subdivision shall make such disclosure in person, except where circumstances reasonably prevent doing so.

(c) A physician or public health officer shall have no obligation to identify or locate any contact except as provided pursuant to title three of article twenty-one of this chapter.

(d) A physician may, upon the consent of a parent or guardian, disclose confidential HIV related information to a state, county, or local health officer for the purpose of reviewing the medical history of a child to determine the fitness of the child to attend school.

(e) A physician may disclose confidential HIV related information pertaining to a protected individual to a person (known to the physician) authorized pursuant to law to consent to health care for a protected individual when the physician reasonably believes that: (1) disclosure is medically necessary in order to provide timely care and treatment for the protected individual; and (2) after appropriate counseling as to the need for such disclosure, the protected individual will not inform a person authorized by law to consent to health care; provided, however, that the physician shall not make such disclosure if, in the judgment of the physician: (A) the disclosure would not be in the best interest of the protected individual; or (B) the protected individual is authorized pursuant to law to consent to such care and treatment. Any decision or action by a physician under this paragraph, and the basis therefor, shall be recorded in the protected individual's medical record.

5. (a) Whenever disclosure of confidential HIV related information is made pursuant to this article, except for disclosures made pursuant to paragraph (a) of subdivision one of this section or paragraph (a) or (e) of subdivision four of this section, such disclosure shall be accompanied or followed by a statement in writing which includes the following or substantially similar language: "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." An oral disclosure shall be accompanied or followed by such a notice within ten days.

(b) Except for disclosures made pursuant to paragraph (c) of subdivision one of this section, or to persons reviewing information or records in the ordinary course of ensuring that a health facility is in compliance with applicable quality of care standards or any other authorized program evaluation, program monitoring or service review, or to governmental agents requiring information necessary for payments to be made on behalf of patients or clients pursuant to contract or in accordance to law, a notation of all such disclosures shall be placed in the medical record of a protected individual, who shall be informed of such disclosures upon request; provided, however, that for disclosures made to insurance institutions such a notation need only be entered at the time the disclosure is first made.

6. (a) The provisions of this subdivision shall apply where a provider of a health or social service possesses confidential HIV related information relating to individuals who are recipients of the service, and a federal, state or local government agency supervises or monitors the provider or administers the program under which the service is provided.

(b) Confidential HIV related information relating to a recipient of such service may be disclosed in accordance with regulations promulgated pursuant to paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article to an authorized employee or agent of such provider or

government agency, when reasonably necessary for such supervision, monitoring, administration, or provision of such service. The term "authorized employee or agent", as used in this subdivision shall only include any employee or agent who would, in the ordinary course of business of the provider or government agency, have access to records relating to the care of, treatment of, or provision of a health or social service to the protected individual.

7. Nothing in this section shall limit a person's or agency's responsibility or authority to report, investigate, or redisclose, child protective and adult protective services information in accordance with title six of article six and titles one and two of article nine-B of the social services law, or to provide or monitor the provision of child and adult protective or preventive services.

8. Confidential HIV related information shall be recorded in the medical record of the protected individual. The provisions of this section shall not prohibit the listing of acquired immune deficiency syndrome, HIV related illness or HIV infection in a certificate of death, autopsy report or related documents prepared pursuant to article forty-one of this chapter or other applicable laws, ordinances, rules or regulations relating to the documentation of cause of death, nor shall this section be construed to modify any laws, ordinances, rules or regulations relative to access to death certificates, autopsy reports or such other related documents. Under no circumstances shall confidential HIV related information be disclosable pursuant to article six of the public officers law. Notwithstanding the foregoing, confidential HIV information obtained pursuant to section 390.15 of the criminal procedure law or section 347.1 of the family court act by either court order or consent of the protected individual shall not be recorded in the medical record of the protected individual unless he or she consents to the recording of such information in a written statement containing the relevant information specified in subdivision two of section two thousand seven hundred eighty-one of this article.

9. Confidential HIV related information shall be disclosed upon the request of the health care worker HIV/HBV advisory panel, established pursuant to article twenty-seven-DD of this chapter, to the panel or its designee only when reasonably necessary for the evaluation of a worker who has voluntarily sought the panel's review.

**§ 2783. Penalties; immunities.** 1. Any person who shall:

(a) perform, or permit or procure the performance of, an HIV related test in violation of section twenty-seven hundred eighty-one of this article; or

(b) disclose, or compel another person to disclose, or procure the disclosure of, confidential HIV related information in violation of section twenty-seven hundred eighty-two of this article; shall be subject to a civil penalty not to exceed five thousand dollars for each occurrence. Such penalty may be recovered in the same manner as the penalty provided in section twelve of this chapter.

2. Any person who willfully commits an act enumerated in subdivision one of this section shall be guilty of a misdemeanor and subject to the penalties provided in section twelve-b of this chapter.

3. There shall be no criminal sanction or civil liability on the part of, and no cause of action for damages shall arise against any physician, his or her employer, or a physician's designated agent, or health facility or health care provider with which the physician is associated, or public health officer, on account of:

(a) the failure to disclose confidential HIV related information to a contact or person authorized pursuant to law to consent to health care for a protected individual; or

(b) the disclosure of confidential HIV related information to a contact or person authorized pursuant to law to consent to health care for a protected individual, when carried out in compliance with this article; or

(c) the disclosure of confidential HIV related information to any person, agency, or officer authorized to receive such information, when carried out in good faith and without malice, and in compliance with the provisions of this article; or

(d) the municipal health commissioner or district health officer's failure to notify contacts pursuant to this chapter.

4. Any cause of action to recover damages based on a failure to provide information, explanations, or counseling prior to the execution of a written informed consent, or based on a lack of informed consent in

the ordering or performance of an HIV related test in violation of this article shall be governed by the provisions of section two thousand eight hundred five-d of this chapter.

**§ 2784. Applicability to insurance institutions and insurance support organizations.** Except for disclosure to third party reimbursers and insurance institutions pursuant to paragraphs (i) and (j) of subdivision one of section twenty-seven hundred eighty-two of this article and except for disclosures pursuant to section twenty-seven hundred eighty-five of this article, the provisions of this article shall not apply to insurance institutions and insurance support organizations, except that health care providers associated with or under contract to a health maintenance organization or other medical services plan shall be subject to the provisions of this article.

**§ 2785. Court authorization for disclosure of confidential HIV related information.**

1. Notwithstanding any other provision of law, no court shall issue an order for the disclosure of confidential HIV related information, except a court of record of competent jurisdiction in accordance with the provisions of this section.

2. A court may grant an order for disclosure of confidential HIV related information upon an application showing: (a) a compelling need for disclosure of the information for the adjudication of a criminal or civil proceeding; (b) a clear and imminent danger to an individual whose life or health may unknowingly be at significant risk as a result of contact with the individual to whom the information pertains; (c) upon application of a state, county or local health officer, a clear and imminent danger to the public health; or (d) that the applicant is lawfully entitled to the disclosure and the disclosure is consistent with the provisions of this article.

3. Upon receiving an application for an order authorizing disclosure pursuant to this section, the court shall enter an order directing that all pleadings, papers, affidavits, judgments, orders of the court, briefs and memoranda of law which are part of the application or the decision thereon, be sealed and not made available to any person, except to the extent necessary to conduct any proceedings in connection with the determination of whether to grant or deny the application, including any appeal. Such an order shall further direct that all subsequent proceedings in connection with the application shall be conducted in camera, and, where appropriate to prevent the unauthorized disclosure of confidential HIV related information, that any pleadings, papers, affidavits, judgments, orders of the court, briefs and memoranda of law which are part of the application or the decision thereon not state the name of the individual concerning whom confidential HIV related information is sought.

4. (a) The individual concerning whom confidential HIV related information is sought and any person holding records concerning confidential HIV related information from whom disclosure is sought shall be given adequate notice of such application in a manner which will not disclose to any other person the identity of the individual, and shall be afforded an opportunity to file a written response to the application, or to appear in person for the limited purpose of providing evidence on the statutory criteria for the issuance of an order pursuant to this section.

(b) The court may grant an order without such notice and opportunity to be heard, where an ex parte application by a public health officer shows that a clear and imminent danger to an individual whose life or health may unknowingly be at risk requires an immediate order.

(c) Service of a subpoena shall not be subject to this subdivision.

5. In assessing compelling need and clear and imminent danger, the court shall provide written findings of fact, including scientific or medical findings, citing specific evidence in the record which supports each finding, and shall weigh the need for disclosure against the privacy interest of the protected individual and the public interest which may be disserved by disclosure which deters future testing or treatment or which may lead to discrimination.

6. An order authorizing disclosure of confidential HIV related information shall:

(a) limit disclosure to that information which is necessary to fulfill the purpose for which the order is granted; and

(b) limit disclosure to those persons whose need for the information is the basis for the order, and specifically prohibit redisclosure by such persons to any other persons, whether or not they are parties to the action; and

(c) to the extent possible consistent with this section, conform to the provisions of this article; and

(d) include such other measures as the court deems necessary to limit any disclosures not authorized by its order.

**§ 2785-a. Court order for HIV related testing in certain cases.**

1. Notwithstanding any contrary provision of law or regulation, a state, county or local public health officer to whom an order or a consent for an HIV test is addressed or sent, in accordance with section 390.15 of the criminal procedure law or section 347.1 of the family court act, must cause HIV related testing to be administered to the subject named therein and, if the test is pursuant to court order, must immediately provide to the court that issued the order a written report specifying the date on which such test was completed. Such report to the court shall not, however, disclose the results of such test. Such officer must disclose the results of the testing to the victim indicated in the order or consent and must also disclose the results to the person tested, unless the person tested has been asked to but declines to authorize such disclosure to himself or herself.

2. At the time of communicating the test results to the subject or the victim, such public health officer shall directly provide the victim and person tested with (a) counseling or referrals for counseling for the purposes specified in subdivision five of section two thousand seven hundred eighty-one of this article; (b) counseling with regard to HIV disease and HIV testing in accordance with law and consistent with subdivision five of section two thousand seven hundred eighty-one of this article; and (c) appropriate health care and support services, or referrals to such available services. If at the time of communicating the test results, the person tested is in the custody of the department of correctional services, division for youth, office of mental health or a local correctional institution, the counseling and services required by this subdivision may be provided by a public health officer associated with the county or facility within which the person tested is confined.

3. Unless inconsistent with this section, the provisions of this article regarding the confidentiality and disclosure of HIV related information shall apply to proceedings conducted pursuant to section 390.15 of the criminal procedure law or section 347.1 of the family court act.

**§ 2786. Rules and regulations; forms; report.** 1. The commissioner shall promulgate rules and regulations concerning implementation of this article for health facilities, health care providers and other persons to whom this article is applicable. The commissioner shall also develop forms to be used for informed consent for HIV related testing and for the release of confidential HIV related information and materials for pre-test counseling as required by subdivision three of section twenty-seven hundred eighty-one of this article, and for post-test counseling as required by subdivision five of section twenty-seven hundred eighty-one of this article. Persons, health facilities and health care providers may use forms for informed consent for HIV related testing, and for the release of confidential HIV related information other than those forms developed pursuant to this section, provided that the person, health facility or health care provider doing so receives prior authorization from the commissioner. All forms developed or authorized pursuant to this section shall be written in a clear and coherent manner using words with common, everyday meanings. The commissioner, in consultation with the AIDS institute advisory council, shall promulgate regulations to identify those circumstances which create a significant risk of contracting or transmitting HIV infection; provided, however, that such regulations shall not be determinative of any significant risk determined pursuant to paragraph (a) of subdivision four of section twenty-seven hundred eighty-two or section twenty-seven hundred eighty-five of this article.

2. (a) Each state agency authorized pursuant to this article to obtain confidential HIV related information shall, in consultation with the department of health, promulgate regulations: (1) to provide safeguards to prevent discrimination, abuse or other adverse actions directed toward protected individuals; (2) to prohibit the disclosure of such information except in accordance with this article; (3) to seek to protect

individuals in contact with the protected individual when such contact creates a significant risk of contracting or transmitting HIV infection through the exchange of body fluids, and (4) to establish criteria for determining when it is reasonably necessary for a provider of a health or social service or the state agency or a local government agency to have or to use confidential HIV related information for supervision, monitoring, investigation, or administration and for determining which employees and agents may, in the ordinary course of business of the agency or provider, be authorized to access confidential HIV related information pursuant to the provisions of paragraphs (l) and (m) of subdivision one and subdivision six of section twenty-seven hundred eighty-two of this article; and provided further that such regulations shall be promulgated by the chairperson of the commission of correction where disclosure is made pursuant to paragraphs (n) and (o) of subdivision one of section twenty-seven hundred eighty-two of this article.

(b) The department of health, in consultation with agencies referred to in paragraph (a) of this subdivision, shall submit a report to the legislature by December first, nineteen hundred eighty-nine, outlining the status and content of such regulations, their effect on the regulated facilities and the protected individuals served by them, the extent to which they conform with current medical and scientific knowledge on the transmissibility of HIV infection, and any recommendations for changes in said regulations.

**§ 2787. Separability.** If any section, clause or provision of this article shall be deemed by any court of competent jurisdiction to be unconstitutional or ineffective in whole or in part, to the extent that it is not unconstitutional or ineffective, it shall be valid and effective and no other section, clause or provision shall on account thereof be deemed invalid or ineffective.

## **Social Services Law, Article 6, Title 1**

**§ 373-a. Medical histories.** Notwithstanding any other provision of law to the contrary, to the extent they are available, the medical histories of a child legally freed for adoption or of a child to be placed in foster care and of his or her birth parents, with information identifying such birth parents eliminated, shall be provided by an authorized agency to such child's prospective adoptive parent or foster parent and upon request to the adoptive parent or foster parent when such child has been adopted or placed in foster care. To the extent they are available, the medical histories of a child in foster care and of his or her birth parents shall be provided by an authorized agency to such child when discharged to his or her own care and upon request to any adopted former foster child; provided, however, medical histories of birth parents shall be provided to an adoptee with information identifying such birth parents eliminated. Such medical histories shall include all available information setting forth conditions or diseases believed to be hereditary, any drugs or medication taken during pregnancy by the child's birth mother and any other information, including any psychological information in the case of a child legally freed for adoption or when such child has been adopted, or in the case of a child to be placed in foster care or placed in foster care which may be a factor influencing the child's present or future health. The department shall promulgate and may alter or amend regulations governing the release of medical histories pursuant to this section.

**§ 383-b. Medical treatment for abused or neglected children; consent of commissioners.** The local commissioner of social services or the local commissioner of health may give effective consent for medical, dental, health and hospital services for any child who has been found by the family court to be an abused child or a neglected child, or who has been taken into or kept in protective custody or removed from the place where he is residing, or who has been placed in the custody of such commissioner, pursuant to section four hundred seventeen of this chapter or section one thousand twenty-two, section one thousand twenty-four or section one thousand twenty-seven of the family court act.



## **Code of Federal Regulations, Title 42, Chapter 1, Part 2, Section 2.14**

### **Part 2 Confidentiality of Alcohol and Drug Abuse Patient Records**

#### **§ 2.14 Minor patients.**

(a) Definition of minor. As used in these regulations the term "minor" means a person who has not attained the age of majority specified in the applicable State law, or if no age of majority is specified in the applicable State law, the age of eighteen years.

(b) State law not requiring parental consent to treatment. If a minor patient acting alone has the legal capacity under the applicable State law to apply for and obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations may be given only by the minor patient. This restriction includes, but is not limited to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. These regulations do not prohibit a program from refusing to provide treatment until the minor patient consents to the disclosure necessary to obtain reimbursement, but refusal to provide treatment may be prohibited under a State or local law requiring the program to furnish the service irrespective of ability to pay.

(c) State law requiring parental consent to treatment. (1) Where State law requires consent of a parent, guardian, or other person for a minor to obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations must be given by both the minor and his or her parent, guardian, or other person authorized under State law to act in the minor's behalf.

(2) Where State law requires parental consent to treatment the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with subpart C of these regulations or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the program director under paragraph (d) of this section.

(d) Minor applicant for services lacks capacity for rational choice. Facts relevant to reducing a threat to the life or physical well being of the applicant or any other individual may be disclosed to the parent, guardian, or other person authorized under State law to act in the minor's behalf if the program director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under subpart C of these regulations to his or her parent, guardian, or other person authorized under State law to act in the minor's behalf, and

(2) The applicant's situation poses a substantial threat to the life or physical well being of the applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf.