

# Working Together

HEALTH SERVICES  
FOR CHILDREN IN  
FOSTER CARE

2009



**New York State  
Office of  
Children and Family  
Services**

# *Working Together*

HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

*NYS Office of Children and Family Services*

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### Introduction

#### Why a Manual on Health Services for Children in Foster Care?

The New York State Office of Children and Family Services (OCFS) is committed to supporting local departments of social services (LDSS, also known as local districts) and voluntary agencies in the provision of adequate, timely health services for children in foster care. This manual is intended to assist and advise foster care and health services staff in focusing attention on this critical issue. As the mental health, developmental, and behavioral needs of children in foster care have increased over the last several years, the provision of health services and coordination of appropriate health care have become more central to achieving their child welfare goals.

All children need health services to identify their condition and needs, diagnose and treat any identified problems, and initiate appropriate follow-up and preventive health care. As a result of health care deprivation and abuse and neglect, children in foster care have a high level of health services needs. Recent research provides the following sobering statistics:

- Approximately 60 percent of children in care have a chronic medical condition, and 25 percent have three or more chronic problems.<sup>1</sup>
- Developmental delays are present in approximately 60 percent of preschoolers in foster care.<sup>2</sup>
- Children in foster care use both inpatient and outpatient mental health services at a rate 15 to 20 times higher than the general pediatric population.<sup>3</sup>
- Between 40 percent and 60 percent of children in foster care have at least one psychiatric disorder.<sup>4</sup>

Children in foster care experience higher rates of physical and emotional problems than those in the general population. This high level of need can be attributed to many factors: exposure to

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<sup>1</sup> M. Szilagyi. "The pediatrician and the child in foster care," *Pediatric Review* 19 (1998), pp. 39-50. N. Halfon, A. Mendonca, & G. Berkowitz. "Health Status of Children in Foster Care: The Experience of the Center for the Vulnerable Child," *Archives of Pediatrics & Adolescent Medicine* 149 (April 1995), pp. 386-392.

<sup>2</sup> Ibid.

<sup>3</sup> S. DosReis, J.M. Zito, D.J. Safer, & K.L. Soeken. "Mental Health Services for Youths in Foster Care and Disabled Youths," *American Journal of Public Health* 91:7 (2001), pp. 1094-1099. J.L. Takayama, A.B. Bergman, F.A. Connell. "Children in Foster Care in the State of Washington: Health Care Utilization and Expenditures," *Journal of the American Medical Association* 271 (1994), pp.1850-1855. N. Halfon, G. Berkowitz, & L. Klee. "Mental Health Services Utilization by Children in Foster Care in California," *Pediatrics* 89 (1992), pp. 1238-1244.

<sup>4</sup> DosReis, 2001.  
Szilagyi, 1998.

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trauma, the pervasive effects of abuse or neglect, inadequate health care or medical neglect before entry into care, the inherent stress of out-of-home placement, and movements between settings that result in interruptions in health services.

The Adoption and Safe Families Act (ASFA) of 1997 provides additional impetus for diligence in addressing the health needs of children in foster care. For the first time, child welfare agencies are being held accountable for improving the well-being of children in foster care in addition to addressing their safety and permanency.

The Fostering Connections to Success and Increasing Adoptions Act of 2008 [Public Law (P.L.) 110-351] furthers the emphasis on ongoing oversight and coordination of health care for children in foster care, including their mental and dental health needs.

Healthy People 2010, an important federal initiative, is a set of health objectives for the nation to achieve during the first decade of the new century. The overarching goals of Healthy People 2010 are:

1. To increase quality and years of healthy life.
2. To eliminate health disparities.

To achieve these public health goals for the nation, programs that provide health services must incorporate the goals into their work. To do our part in this national public health effort, we have included references to applicable Healthy People goals for children and adolescents in this manual.

## Audience and Organization of the Manual

We recognize that there are different health care delivery models for children in foster care across New York State. How children receive health services varies depending on whether they are placed in a foster home supervised by the LDSS (direct care) or in a setting operated by a voluntary authorized agency (indirect care). For the purposes of this manual, we refer to both LDSS and voluntary agencies as “agencies.”

In addition, health services may be provided directly by the LDSS or agency, or by providers in the community. These differences are taken into account throughout the manual.

Our intended audience is case managers, case planners, caseworkers, health care coordinators, health services staff, and any other agency personnel who coordinate or oversee the health needs of children in foster care. The manual is not designed for caregivers or health care providers. However, parts of this manual may be used to educate health care providers and caregivers about the health care guidelines for children in foster care.

Chapters address the initial evaluation of the child’s health, ongoing and preventive health care, specific health services, medication administration and management, health care coordination, issues of consent and confidentiality specific to children in foster care, maintenance of health records, working with health care providers, and ways to support caregivers. At the end of each chapter you will find helpful resources such as website addresses, program descriptions, and sample tools.

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Appendix A contains sample forms and a list of the websites cited in the manual. The sample forms are provided to assist you in organizing the tasks and information described in the manual. Feel free to adapt them as appropriate. Appendix B contains copies of health-related policy documents issued by OCFS. Appendix C contains copies of critical regulations and laws cited in the manual. Appendix D contains the Protocol: Children in Foster Care Who Participate in the Early Intervention Program. Appendix E provides space for you to insert local policies and forms.

## Key Concepts

### Health Services Guidelines for Children in Foster Care

In 2001, the Office of Children and Family Services developed health services guidelines for children in foster care to provide local districts and voluntary agencies with clear instructions for arranging and coordinating the health care of these children. The guidelines outline the mandated and recommended health services activities needed to support optimal health for children in foster care and comply with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards and state regulations.

**➔ EPSDT defines the minimum federal Medicaid required services. The New York State version of EPSDT is known as the Child/Teen Health Plan (C/THP). As children in foster care are now categorically eligible for Medicaid if they are citizens or meet satisfactory immigration status, it is our responsibility to implement this set of core services. In addition, we have included recommendations for best practice to promote optimal health. These are based on research on the health needs of children in foster care. You are encouraged to use your available resources to provide all recommended as well as required services.**

Contained within the guidelines are descriptions of the services necessary to address children's health needs, time frames to accomplish required health activities, qualifications for health care providers, and important concepts around health care coordination, monitoring of health services, and administrative issues. This manual incorporates the guidelines along with other helpful resources and suggestions for managing health services for children in foster care.

**Note:** The resources listed in this manual are intended to enhance the assessment of health care needs and the delivery of health services to children in foster care, and are not specifically endorsed by the Office of Children and Family Services. Sources for the documents are provided, and the author is responsible for the content. Listings of websites and organizations are included to provide helpful information and tools for foster care and health staff working together with children and families.

The guidelines are drawn from the following sources:

- Federal Medicaid EPSDT (Early and Periodic Screening, Diagnostic and Treatment) standards.
- New York State Medicaid C/THP (Child/Teen Health Plan) standards.

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- New York State Codes, Rules and Regulations (NYCRR) applicable to services for children in foster care.
- New York State OCFS policy documents applicable to children in foster care.
- New York State Mental Hygiene Law (MHL).
- New York State Public Health Law (PHL).
- New York State Social Services Law (SSL).
- Child Welfare League of America (CWLA) Standards for Health Care Services for Children in Out of Home Care.
- American Academy of Pediatrics (AAP): policy statement, Health Care of Children in Foster Care; and *Fostering Health: Health Care for Children in Foster Care in New York State*.
- Other relevant sources.

➔ **Footnote citations to a law or regulation indicate that an activity or component is *required* and provide the legal or regulatory source for the requirement. Use of the term “should” indicates that an activity is recommended by OCFS as best practice but is not required by law or regulation.**

**Note:** Language with footnote citations may not be quoted verbatim from the particular source. Appendix B contains links to relevant policies, and Appendix C contains links to selected regulations and laws.

### Comprehensive Health Evaluation: Five Assessment Domains

The health needs of children fall into five different domains: medical, dental, developmental, mental health, and substance abuse. Although there is overlap across the areas, each has a unique focus with specialty health practitioners and diverse assessment and treatment protocols. All five domains warrant assessment and special consideration. For this reason, information is organized in the manual according to these five domains.

### Health Care Coordination

The overarching theme of the manual is “working together” to promote optimal health of children in foster care. This means health care professionals, casework staff, agency staff, caregivers, birth parents, and service providers working collaboratively toward implementing an integrated plan of care. To make this happen effectively, the function of health care coordination is crucial. Simply put, health care coordination is a series of activities that support oversight and responsibility for all aspects of health services for children in foster care. Throughout the manual, “health care coordination activities” are highlighted to indicate ways that staff can coordinate health services and integrate them into permanency planning and case management.

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Health care coordination activities may be conducted by a variety of individuals, such as the case manager, foster parent, or agency health services staff. It is recommended that a lead person with a health background be identified to provide or assist with health care coordination. We recognize that local districts and voluntary agencies conduct activities differently and have different staffing patterns. The term “staff” is used to indicate any staff involved with health care coordination.

*(See Chapter 4, Health Care Coordination, and Appendix B for the guidance paper, Health Care Coordination for Children in Foster Care: Approaches and Benefits (09-OCFS-INF-01).*

### Medical Home

When feasible, children should receive all of their health care, including routine preventive, acute illness, and chronic illness, from the same provider prior to foster care placement, while in foster care, and upon discharge, to promote continuity of care. In this model of care, every child has an established, ongoing relationship with a primary health care provider, so that health problems can be identified, treated, and documented early to improve outcomes and reduce the likelihood of disease, disability, and hospitalization.

The concept of the medical home is woven throughout the manual beginning with the initial comprehensive health evaluation.

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### Chapter One

## Initial Evaluation of Child's Health

Certain initial medical activities are required and/or recommended when a child is placed in foster care. This is the time to gather as much medical history as possible on the child and family and to begin a comprehensive evaluation of the child's medical, dental, mental health, developmental, and substance abuse needs. The initial health evaluation should result in a comprehensive needs/problem list and plan of care that addresses all of the child's identified health needs.

Whether a child in placement continues on medications previously prescribed or continues a relationship with a specialized practitioner (or needs a referral to one) are crucial decisions. Health care coordination plays a vital role in seeing that (a) all necessary health-related services are provided in the specified time frames; (b) the caregiver supports the medical plan for the child; (c) information is shared appropriately among professionals involved in the child's care; and (d) the child's parents are involved in the planning and treatment (*see Chapter 4, Health Care Coordination*).



Sections in this chapter include:

Chart: Health Services Time Frames

1. Initial screening
2. Information gathering
3. Comprehensive health evaluation
  - Initial medical assessment
  - Initial dental assessment
  - Initial mental health assessment
  - Initial developmental assessment
  - Initial substance abuse assessment
4. HIV risk assessment
5. Follow-up health evaluation
6. Child abuse and neglect health evaluation
7. Resources

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### Health Services Time Frames

The chart below outlines the time frames for initial health activities, to be completed within 60 days of placement. The column labeled Mandated indicates whether an activity is required. The “M” in the time frame column indicates that the activity is required within a mandated time frame. Initial health activities include:

- Immediate screening of the child’s medical condition, including assessment for child abuse/neglect.
- Immediate efforts to obtain medical consent.
- Immediate attention to HIV risk assessment.
- Comprehensive health evaluation: A series of five assessments provides a complete picture of the child’s health needs and is the basis for developing a comprehensive problem list and plan of care.
- Follow-up health evaluation that incorporates information from the five initial assessments.
- Ongoing efforts to obtain child’s medical records and document medical activities.

#### INITIAL HEALTH SERVICES TIME FRAMES

Time Frame	Activity	Mandated	Who Performs
24 Hours	Initial screening/screening for abuse/neglect		Health practitioner (preferred) or caseworker/health staff
5 Days <b>M</b>	Initial determination of capacity to consent for HIV risk assessment & testing	<b>X</b>	Caseworker or designated staff
5 Days <b>M</b>	Initial HIV risk assessment for child without capacity to consent	<b>X</b>	Caseworker or designated staff
10 Days <b>M</b>	Request consent for release of medical records & treatment	<b>X</b>	Caseworker or health staff
30 Days <b>M</b>	Initial medical assessment	<b>X</b>	Health practitioner
30 Days <b>M</b>	Initial dental assessment	<b>X</b>	Health practitioner
30 Days	Initial mental health assessment	<b>X</b>	Mental health practitioner
30 Days <b>M</b>	HIV risk assessment for child with possible capacity to consent	<b>X</b>	Caseworker or designated staff
30 Days <b>M</b>	Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection	<b>X</b>	Caseworker or health staff
45 Days	Initial developmental assessment	<b>X</b>	Health practitioner
45 Days	Initial substance abuse assessment		Health practitioner
60 Days	Follow-up health evaluation		Health practitioner
60 Days <b>M</b>	Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent & assessed to be at risk of HIV infection	<b>X</b>	Caseworker or health staff
60 Days <b>M</b>	Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	<b>X</b>	Caseworker or health staff

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### 1 Initial Screening

Each child entering foster care should receive a health screening within 24 hours of placement. The purpose is to observe the child and gather information to identify active health problems and needs for immediate care and to continue medications, if any. Use of a screening checklist can help identify and document:

- Signs of abuse or neglect. (If trauma is present, seek immediate medical attention.)
- Active medical/psychiatric problems: obvious illnesses, injuries, or disabilities.
- Current medications, if any.
- Allergies to food, medication, and environment (e.g., pets, pollen).
- Upcoming medical appointments.
- Need for eyeglasses, hearing aids, or other durable medical equipment (e.g., prosthetic devices).
- For an infant: delivery history (e.g., where, when, how, toxicology screen, complications).

*(See Appendix A for a sample Admission Screening Interview tool.)*

It is recommended that a qualified health care practitioner (RN, LPN, physician, nurse practitioner, or physician's assistant) conduct the screening. A caseworker trained to use the screening tool may also conduct the screening, if necessary. If the screening identifies an active health problem and need for immediate care, follow your agency's procedures to address this need. *Emergency rooms should not be used for routine screening.*

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## 2 Information Gathering

At the time of placement, make every effort to obtain the child's complete medical history. Try to obtain information from the birth parents, the child (if appropriate), health care providers, other service providers (e.g., school nurse, day care center), and existing medical records (*see Chapter 8, Maintaining Health Records*). Whenever possible, the caseworker should gather medical information at the time of the child's removal from the home.

(*See Appendix A for sample Health History Interview With Family form and a Medical Review of Systems form, which can guide staff in obtaining a more thorough health history on the child from a family member or caregiver.*)



### Health Care Coordination Activities

To prepare for the initial health assessments, gather the following information on the child's medical history:

- Prior and current illnesses and behavioral health concerns.
- Immunization history (*see next page*).
- Medications (prescription and over-the-counter).
- Allergies (food, medication, and environmental).
- Results of diagnostic tests and assessments, including developmental and psychological tests.
- Results of laboratory tests (including HIV antibody screening).
- Family history of hereditary conditions or diseases.
- Details of pregnancy, labor, and delivery (for children age 5 and under, and as available for other children).
- Results of the infant's Newborn Screening (*see Chapter 3 Newborn Screening Program*)
- Names and addresses of the child's health and medical provider(s), with details of illnesses, accidents, and previous hospitalizations, including psychiatric hospitalizations.
- Durable medical equipment/adaptive devices currently used or required by the child (e.g., wheelchair, feeding pump, glasses).
- Needed follow-up or ongoing treatment for active problems.

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### Immunization History

To prevent children from receiving additional, unnecessary immunizations when they enter foster care, it is important to obtain all documentation of previous immunizations and maintain an updated list in the child's health file. There are generally four sources where staff can obtain the child's immunization history: the health care practitioner, the family, the child's school, and the New York State Immunization Information System or the Citywide Immunization Registry.

- Ask the birth parent or guardian to identify the provider or clinic where the child received immunizations, and send a request for copies of the records.
- Obtain a copy of immunization cards or documentation that the birth parent or guardian has received from the provider.
- Obtain a copy of immunization records from the school for school-age children.

#### New York State Immunization Information System

The New York State Immunization Information System (NYSIIS) was created in response to legislation requiring health care providers to report all immunizations administered to persons less than 19 years of age beginning January 1, 2008. If the child receives a vaccine after that date, all past immunizations must also be recorded in NYSIIS. When a child receives a vaccination at a location outside of New York City, information should be entered into NYSIIS.

Authorized users of NYSIIS include health care providers, schools, and commissioners of local social services districts. (*Note: NYSIIS is not yet fully implemented.*) The health care provider at the Initial Medical Assessment can also search NYSIIS for records. The system can accommodate different addresses and different names under which the child may be known. If you have obtained documentation of immunizations that have not yet been entered into NYSIIS, ask the provider to record them in NYSIIS. You may contact the NYSIIS team at 518-473-2839.

#### Citywide Immunization Registry

When a child receives an immunization at a location in New York City, the information must be entered into the Citywide Immunization Registry (CIR). The Administration for Children's Services (ACS) is authorized to access information from the CIR, as are voluntary foster care agencies. Agencies that provide health services in New York City are required to report immunizations to the CIR. You may contact the CIR at 212-676-2323 or online at: <http://www.nyc.gov/html/doh/html/cir/index.html>.

The NYSIIS and CIR systems will soon be able to exchange information freely. (*See section 7, Resources, for the NYS and NYC Recommended Childhood Immunization Schedule.*)

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### Consent

Request consent for release of medical records and consent for routine medical treatment from the birth parent or guardian within 10 days of the child's placement in foster care<sup>1</sup> (*see Chapter 6, Medical Consents*).

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<sup>1</sup> 18 NYCRR 441.22(d).

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### 3 Comprehensive Health Evaluation

To develop a full understanding of a child's health, a comprehensive health evaluation comprising five assessments should take place within certain time periods after the child's entry into foster care. These include:

- Medical assessment (within 30 days)
  - Dental assessment (within 30 days)
  - Mental health assessment (within 30 days)
  - Developmental assessment (within 45 days)
  - Substance abuse assessment (within 45 days)
- The Office of Children and Family Services (OCFS) recommends that a full comprehensive health evaluation as described in this chapter be completed for each child in foster care. Footnote citations to a law or regulation indicate that an activity or component is *required* and provide the legal or regulatory source for the requirement. Use of the term “should” indicates that an activity is recommended by OCFS but is not required by law or regulation.**

Assessments and services for children in foster care are described here as falling into five domains: medical, dental, mental health, developmental, and substance abuse. This model recognizes that there are multiple aspects of wellness for children in care. The descriptions of each assessment provide guidance on the components involved and the considerations to be taken into account by the health provider. Though there are five assessment domains, there need not be five different clinicians. Some providers are well qualified to conduct more than one assessment. For example, a pediatrician will routinely assess the developmental status as well as physical health of an infant.



#### Health Care Coordination Activities

The following staff activities are provided to support the completion and needed follow up for the health assessments:<sup>2</sup>

- Scheduling the examination for the child or helping the foster parent schedule it within the required time frame.
- Offering to provide or arrange for transportation as needed.<sup>3</sup>
- Providing the practitioner with the child's available medical history at the time of the exam or as soon as possible thereafter.

<sup>2</sup> 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

<sup>3</sup> 18 NYCRR 441.22(j)(2).

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- Making sure that the practitioner is familiar with the requirements of a comprehensive examination for children in foster care.
- Following up to make sure that the examination is completed and appropriate actions are taken, including filling prescriptions.
- Making sure that the results of the initial medical assessment and any referrals for follow-up care are filed in the medical section of the child's Uniform Case Record (UCR)<sup>4</sup> or Family Assessment Service Plan (FASP) and documented electronically, as required.

### Initial Medical Assessment

Each child entering foster care must receive an initial medical assessment within 30 days of placement.<sup>5</sup> If it is documented that the child has had such an assessment within 90 days before placement, and the results are available, the examination does not need to be repeated unless medically indicated or if there are allegations of abuse or maltreatment that require medical attention. In this case, obtain a copy of the assessment to determine if appropriate treatment and follow-up have occurred for identified issues.

Practitioners providing this assessment may include:

- Physicians
- Nurse practitioners
- Physician assistants

The qualified practitioner should be experienced in providing comprehensive primary care for infants, children, and adolescents in foster care.

Institutional regulations require – and quality practice would dictate – that all providers be licensed, certified, and registered in New York State to practice their profession.<sup>6</sup>

### Medical Home

When feasible, children should receive all of their health care, including routine preventive, acute illness, and chronic illness, from the same provider while in foster care. In this model of care, every child has an established, ongoing relationship with a primary health care provider, so that health problems can be identified, treated, and documented early to improve outcomes and reduce the likelihood of disease, disability, and hospitalization. Health providers outside the medical home should consult with the primary care provider and share their findings (with appropriate consent) to facilitate comprehensive, coordinated care. This is particularly important when the child is referred to subspecialists for diagnostic evaluations and/or treatment, and when services are ordered in other

<sup>4</sup> 18 NYCRR 441.22(k) and 428.3(b)(4)(ii).

<sup>5</sup> 18 NYCRR 441.22(c)(1) (“comprehensive medical examination”).

<sup>6</sup> 18 NYCRR 442.18.

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settings (e.g., occupational or speech/language therapy).<sup>7</sup> The medical home provides continuity of health care despite any changes in placement.

The initial medical assessment provides the opportunity to establish a “medical home” with one primary care provider who is familiar with the child’s needs from placement to discharge and beyond. In the interest of maintaining a medical home, talk to the practitioner about continuing to follow the child and keeping a complete record of the child’s medical history and referrals.

A medical home is not a building, house, or hospital, but rather an approach to providing health care services in a high-quality and cost-effective manner. Children and their families who have a medical home receive the care they need from a pediatrician or physician (pediatric health care professional) whom they trust. The pediatric health care professionals and parents [or other caregivers] act as partners in a medical home to identify and access all the medical and non-medical services needed to help children and their families achieve their maximum potential. The American Academy of Pediatrics believes that all children should have a medical home where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. (*American Academy of Pediatrics*)

### Components of Medical Assessment

The initial medical assessment<sup>8</sup> must include (1) a medical and developmental history; (2) a physical examination by a qualified medical professional; (3) screening tests; (4) preventive services; and (5) development of a problem list and treatment plan.

1. Medical history – building on the information from the initial screening, if available:
  - Identify past providers and seek records.<sup>9</sup>
  - Obtain information from parent or guardian whenever possible.
  - Obtain immunization records.
  - Review all available medical information.
  - Obtain developmental history
    - Birth family history of developmental problems.
    - History of psychosocial issues prior to placement.
    - Previous developmental assessments and treatments, if any.

Having this information at hand will be helpful for the primary care provider when conducting the initial medical assessment.

2. Complete unclothed physical examination in accordance with current recommended medical practice, taking into account the age, environmental background, and development of the child.

The examination must include observation for child abuse and neglect, which, if suspected, must

<sup>7</sup> EPSDT/CTHP *Provider Manual for Child Health Plus A (Medicaid)* (2005), p. 19.

<sup>8</sup> 18 NYCRR 441.22(c)(2).

<sup>9</sup> 18 NYCRR 441.22(e).

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be reported to the State Central Register of Child Abuse and Maltreatment (*see section 6, Child Abuse and Neglect Health Evaluation*). The exam must also include observation for dental problems in children under 3 years old and referral to a dentist if problems are found.

3. Screening tests appropriate for age, identified risks, and identified conditions:
  - Laboratory and sensory screening appropriate for age per the American Academy of Pediatrics (AAP) including appropriate vision, hearing, and dental screening.
    - Urinalysis.<sup>10</sup>
    - If AAP recommends “risk assessment to be performed, with appropriate action to follow, if positive,” the tests referenced should be conducted for all adolescents entering foster care during the initial medical assessment (e.g., cholesterol and lipids).
  - Screening for lead poisoning, anemia, tuberculosis, HIV, and hepatitis B exposure due to higher risk status of children in foster care.
  - Special screening tests for children with specific medical conditions or risks such as HIV, fetal alcohol syndrome, sickle cell disease, diabetes, or seizures, consistent with current standards for primary care of the particular condition that is present in the child.
4. Preventive services, such as immunizations, health education, and anticipatory guidance appropriate for the child’s age.
5. Development of a problem list and treatment plan.

### Additional Time Frames for the Medical Assessment

A comprehensive medical assessment must be completed within 30 days after a child returns to foster care following discharge, trial discharge, or absence without consent that lasted more than 90 days.<sup>11</sup> At the discretion of the agency, the examination may be completed if there are concerns about a child’s health when:

- The child returns to care *within* 90 days following discharge, trial discharge, or absence from care without consent.
- The child is transferred to the care of another agency, and the receiving agency determines that a comprehensive medical examination may be necessary to help formulate the child’s service plan.<sup>12</sup>
- There are allegations of abuse or maltreatment.
- There are concerns that the child has been involved with alcohol, drugs, or sexual activity during an absence without consent.

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<sup>10</sup> 18 NYCRR 508.8(b)(9).

<sup>11</sup> 18 NYCRR 441.22(c)(3).

<sup>12</sup> 18 NYCRR 441.22(c)(4).

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### Initial Dental Assessment

An initial dental assessment must be conducted within 30 days of placement.<sup>13</sup> If it is documented that the child has had such an assessment within 90 days before placement, and the results are available, the assessment does not need to be repeated unless medically indicated. In this case, obtain a copy of the assessment to determine if appropriate treatment and follow-up have occurred for identified issues.

The assessment includes:

- Dental history and screening.
- For children under age 3, referral for dental care when a medical provider finds problems upon examining the child's mouth.
- For children age 3 and older, diagnostic examination by a dentist.<sup>14</sup> [*Note: NYC Administration for Children's Services (ACS) requires an exam by a dentist at age 2.*]

The following is recommended:

- Dental x-rays as indicated for diagnostic examination.
- Routine prophylaxis consistent with current dental practice for age:
  - Cleaning
  - Topical fluoride
  - Oral hygiene instruction to the child and caregiver
- Sealants on permanent molars.
- Dental problem list and treatment plan.
- Referral to a dentist and establishment of a dental home is recommended no later than 6 months after the first tooth erupts, or by 12 months of age, whichever comes first. This practice allows the dentist to assess risk and recommend interventions. It also provides an opportunity for the dentist to intervene in the oral hygiene habits of the primary caregivers to reduce the risk of colonization of the infant by the bacteria that cause tooth decay.

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<sup>13</sup> 18 NYCRR 441.22(c)(2)(vii).

<sup>14</sup> 18 NYCRR 441.22(f)(2)(viii).

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### Initial Mental Health Assessment

The initial mental health assessment must be conducted for children age 3 and older. It is recommended that this be completed within 30 days of placement. Although not explicitly required in NYS OCFS regulations, Early Periodic Screening, Diagnosis and Treatment (EPSDT) requires an assessment of mental health development for all Medicaid eligible children,<sup>15</sup> and AAP recommends a psychosocial/behavioral assessment at each checkup.<sup>16</sup> OCFS regulations specify that psychiatric and psychological services must be made available appropriate to the needs of children in foster care.<sup>17</sup>

The assessment includes (1) a mental health assessment conducted by a qualified mental health professional; (2) development of a mental health needs list; (3) list of child's strengths; and (4) development of a mental health treatment plan.



#### Health Care Coordination Activities

Before the mental health assessment takes place, you can help further the process by gathering records on the child's past mental health issues, diagnoses, and treatment, if any. After the assessment is completed, you will be involved in supporting the child's mental health treatment plan, including working with the child's caregivers, birth parents, and service providers. It is a good idea to arrange for mental health providers to share appointment information with you to better monitor attendance at appointments.

Practitioners providing the assessment may include:

- Physicians experienced in providing mental health services:
  - Developmental/behavioral pediatricians for children under age 5.
  - Child and adolescent psychiatrists or general psychiatrists with experience in the care of children and adolescents.
- Licensed clinical psychologists with training and/or experience with emotional problems of children and adolescents.
- Nurse practitioners with certification in child and adolescent psychiatry.
- Certified psychiatric clinical nurse specialists.
- Licensed clinical social workers (LCSWs) or licensed master social workers (LMSWs) with

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<sup>15</sup> EPSDT 5123.2A.

<sup>16</sup> <http://practice.aap.org/content.aspx?aid=1599>.

<sup>17</sup> 18 NYCRR 441.15.

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training and/or experience with the emotional problems of children and adolescents.

**Note:** LMSWs may only provide clinical social work services under supervision.

### Components of Mental Health Assessment

The purpose of the mental health assessment is to obtain a complete picture of the child who has just been placed in foster care and to identify any emotional and behavioral needs, issues, or problems or risk thereof arising from the child's situation. Most children in foster care have experienced multiple traumas such as abuse or neglect, witnessing domestic violence, or parental absence due to mental illness or substance abuse. Factors such as removal from the home, separation from parents and siblings, changing schools, and changing foster homes can also place additional stress on the child's emotional stability.

The practitioner derives this picture by obtaining the child's history, interviewing the child, caregivers, and birth parents and completing the following assessment components. It may take more than one interview to obtain the needed information and determine if the child has a mental health disorder or need for treatment.

1. Mental health/psychiatric history – obtained by interviewing the child, family, and caregivers, covering the following information:
  - Identifying information
  - Past psychiatric history
  - Past and current psychiatric medications
  - Identification of individual strengths/assets
  - Identification of individual deficits/liabilities
  - Developmental history
  - School history, including reports and assessments
  - Family history
  - Social and behavioral history
  - Medical history (including results of initial medical assessment and prenatal exposure to alcohol or drugs)
  - History of drug/alcohol use by the child
  - Trauma and abuse history
2. Mental status examination – accomplished by interviewing the child and examining the child's appearance, behavior, feeling (affect and mood), perception, thinking, and orientation to time, place, and person.
3. Assess the circumstances of placement, family life events, and traumatic events, and observe for signs and symptoms:
  - Risks for suicide, self-mutilating behaviors, and/or violence
  - Substance exposure, misuse, abuse, and addiction
  - Maltreatment, including physical, sexual, emotional abuse and neglect
  - Risk of placement disruption
  
  - Risky sexual behavior

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- Risk of antisocial behavior
- 4. If clinically indicated, completion of diagnostic screening and assessment tools (behavior, mood, etc.) (*see section 7, Resources, for a list of assessment tools*).
- 5. If clinically indicated, perform psychological testing
- 6. Identification of mental health symptoms and/or diagnosis that must be addressed (*see Chapter 2, Preventive and Ongoing Health Care, for information on the DSM-IV-TR Manual*).
- 7. Mental health treatment plan for the child's identified needs, consisting of treatment goals, treatment objectives, and treatment methods/interventions/services (types, frequency, specific providers).

### Guidance for Caregivers

You have an important role in helping foster parents or childcare staff understand the mental health needs of the child placed in their care. If information regarding the trauma experienced by the child and any mental health symptoms or diagnosis are known at the time of placement, discuss these with the caregivers so that they can be more aware of the child's needs. As the child becomes more comfortable in the placement setting, he or she may begin to exhibit certain different behaviors. This is a critical time to support caregivers and provide practical guidance and training to address these changes. Caregivers should be aware of this possibility, make note of the child's behavior, and pass the information on to the person conducting the mental health assessment. It is important to realize that the child may be reacting to feelings of separation, loss, or rejection, and his or her behavior may be more a reflection of the situation than an indicator of a genuine mental illness.

Some of the behaviors that caregivers should be alert to are:

- Angry outbursts.
- Excessive sadness and crying.
- Withdrawal.
- Lying or stealing.
- Defiance.
- Unusual eating habits, such as hoarding food or loss of appetite.
- Sleep disturbances.
- Sexual acting out, such as seductive behaviors toward caregivers.
- Change in behavior at school, including truancy.

Please note that if the child appears to be in crisis, immediate referral to the mental health provider should be made. If a foster parent identifies a child in crisis, he/she should contact the caseworker immediately.

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### Initial Developmental Assessment

An initial developmental assessment must be conducted for children entering foster care. It is recommended that this be completed within 45 days of placement. Although not explicitly required in NYS OCFS regulations, EPSDT requires a developmental assessment for all Medicaid eligible children,<sup>18</sup> and regulations require a developmental history.<sup>19</sup>

The assessment includes (1) a developmental history; (2) a clinical assessment; and (3) an individual service plan.

The purpose of the initial developmental assessment is to examine the child's growth and development in relation to his or her age and expected milestones. Adequate knowledge about a child's development supports better placement, custody, and treatment decisions. Many children in foster care have not grown up in an environment that supports the achievement of developmental milestones. Negative environmental conditions, including lack of stimulation, child abuse, or violence within the family, impact and may impair brain development, particularly in very young children.

Practitioners providing this component may include:

- Professionals with formal training and experience evaluating child development appropriate to the age of the child (*see above section on mental health assessment*).
- The same professional performing the medical examination if appropriately qualified.

### Components of Developmental Assessment

The components of a developmental assessment include:<sup>20</sup>

1. A developmental history – obtained by interviewing the child, family, and caregivers, covering the following information:
  - Age at which developmental milestones were achieved (e.g., age when child first walked or talked)
  - Results of previous developmental and educational assessments
  - Medical history (including results of initial medical assessment)
  - History of prenatal exposure to alcohol or drugs, including the type of substance, amount, and when during pregnancy exposure occurred
  - History of trauma, abuse, and neglect
  - Quality of the child's important relationships prior to placement
2. A clinical assessment of:

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<sup>18</sup> EPSDT 5123.2A.1.

<sup>19</sup> 18 NYCRR 441.22(c)(2).

<sup>20</sup> *Pediatrics*, 106(5) (November 2000), 1145-1150.

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- Gross motor skills
- Fine motor skills
- Cognition
- Expressive and receptive language
- Self-help abilities
- Emotional well-being
- Coping skills
- Relationships to persons
- Adequacy of caregiver's parenting skills
- Behaviors

Assessment tools vary according to the child's age, developmental stage, and previous history. Measures used should be standardized and validated.

2. Creation of a developmental treatment plan (individual service plan) for identified needs, consisting of treatment goals; treatment objectives; and treatment methods, interventions, and services including types, frequency, and specific providers.

### Initial Substance Abuse Assessment

An initial substance abuse assessment should take place within 45 days of placement for children age 13 and older, and younger if indicated. Although not explicitly required in NYS OCFS regulation,<sup>21</sup> the OCFS health services guidelines recommend this assessment be considered for children age 10 and older, as either an independent activity or a component of the mental health assessment. Standards for services to Medicaid eligible adolescents require an assessment of psychosocial adjustment, including use of drugs, alcohol, and tobacco.

The purpose of the assessment is to determine whether the child is currently using drugs, alcohol, or tobacco or is at risk of using them. A thorough assessment also considers substance use in the child's family.

**Note:** "Substance" or "drug" includes all alcohol and chemicals, including prescribed pharmaceuticals, improperly used either by inhalation, smoking, ingestion, or injection.

Practitioners providing this component may include:

- Qualified health professionals with adolescent development and addiction training and experience.
- Certified alcohol and substance abuse counselors (CASAC) practicing in an approved work setting.<sup>22</sup>
- Psychologists with MSWs with adolescent development and addiction training and experience.

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<sup>21</sup> 18 NYCRR 508.8(b)(4)(iii).

<sup>22</sup> 14 NYCRR 853.3(b).

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- LCSWs or LMSWs with adolescent development and addiction training and experience.

The assessment should be consistent with current standards of care for adolescent substance abuse assessments (*see section 7, Resources, for Screening and Assessing Adolescents for Substance Use Disorders*). The American Academy of Pediatrics (AAP) and the New York State Office of Alcohol and Substance Abuse Services (OASAS) recommend the use of the “CRAFFT” substance abuse screening instrument, which is developmentally appropriate for adolescents, and which provides a practical means of quickly identifying youth in this age group who will need more comprehensive assessment or referral to substance abuse treatment specialists (*see section 7, Resources*).

Based on the assessment and any identified problems, a treatment plan will be developed that includes recommendations for counseling and other services for the child and family.

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### 4 HIV Risk Assessment

Children entering foster care must be assessed for their risk of HIV exposure, capacity to consent to an HIV test, and HIV testing history.<sup>23</sup> Each child entering foster care 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.

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.

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; and determine whether the child has the capacity to consent to HIV-related testing.

The risk assessment must be performed by designated staff who are trained in HIV risk assessment, able to assess a child's capacity to consent, and familiar with the special HIV confidentiality requirements.

*(See Chapter 3, Special Health Care Services, for information on HIV-related assessment and services and Chapter 6, Medical Consents, for information on capacity to consent.)*

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<sup>23</sup> 18 NYCRR 441.22(b); 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure.

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### 5 Follow-Up Health Evaluation

A follow-up health evaluation with the primary care provider should take place when all assessments are completed, approximately 60 days after the child's entry into care.

Activities of the follow-up health evaluation include, at a minimum:

- Continue to update immunizations for age.
- Review results of all assessments and laboratory and other screening tests.
- Review new information emerging during placement (e.g., mental health issues, substance abuse) and update the treatment plan accordingly.
- Review compliance with appointments to make sure all planned follow-up has occurred.
- Plan continuing care.
- Review compliance with treatment recommendations, including medication.



#### Health Care Coordination Activities

Make sure that the medical home (primary care provider) has received the results of each initial assessment. The follow-up health evaluation provides an opportunity for the primary care provider to review the child's strengths and needs as identified in the initial assessments and develop an overall plan of care for the child. Communicate this plan to the child's treatment team and all specialty providers.

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### 6 Child Abuse and Neglect Health Evaluation

A child abuse and neglect health evaluation is a medical examination conducted by a health care practitioner for the purpose of identifying, documenting, and treating any signs and/or symptoms of abuse or neglect. This evaluation may be integrated into an initial or routine physical or mental health exam. It may also be a separate activity at any time that suspicions of abuse or neglect arise. A thorough evaluation addresses both the physical and emotional aspects of the child's well being. Medically, the child will need treatment for injuries and other physical complaints. Just as important is the identification and treatment of the functional and emotional consequences of abuse or neglect. This should include referrals to skilled mental health providers. All health care providers involved in the child's treatment plan should know when the child's needs are related to suspected abuse or neglect, and the plan must address these needs.

Health care practitioners as well as caseworkers and caregivers need to be vigilant in observing the child for signs of abuse and neglect. Identification and documentation of child abuse and neglect should be an ongoing activity that begins with the initial screening (within 24 hours of placement) and must be a part of every medical contact.

If there is reasonable cause to suspect abuse or maltreatment, an immediate call should be made to the State Central Register of Child Abuse and Maltreatment (SCR). Keep in mind that caseworkers, childcare staff, and licensed health professionals are mandated reporters under state law.<sup>24</sup> The telephone number for reporting suspected abuse and maltreatment to the SCR for mandated reporters is 1-800-635-1522, and the number for the general public is 1-800-342-3720.

All in-depth interviews related to abuse or neglect, especially sexual abuse, should be conducted by qualified and experienced professionals. It is not the role of the foster parents or caregivers to take on this task.

#### Time Frames

A child abuse and neglect evaluation should take place:

- Prior to or within 24 hours of placement.
- At the initial medical assessment.<sup>25</sup>
- At periodic health visits.<sup>26</sup>
- Immediately, when specific indicators of abuse or neglect are present.

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<sup>24</sup> SSL Article 6, Title 6, 413-415.

<sup>25</sup> 18 NYCRR 441.22(c)(2).

<sup>26</sup> 18 NYCRR 441.22(f)(2).

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- Within 24 - 48 hours of return when a child returns from trial discharge or has been absent without leave (AWOL).
- Within 24 - 48 hours before discharge.

### Time Frames for a Sexual Abuse Evaluation

The timing of a sexual abuse health evaluation depends on when the suspected abuse occurred. If the sexual abuse occurred more than four days prior to the disclosure, it is more important to have the examination conducted in a child-friendly, non-threatening environment than to adhere to strict time frames for seeking the medical evaluation. The assessment and interview process should begin immediately and medical attention sought as soon thereafter as possible and appropriate. If there are suspicions that a caregiver or someone with regular access to the child is the abuser, immediate action must be taken to protect the child regardless of when the abuse occurred. Involve child protective services as appropriate.

A medical exam should take place:

- On the same day if the sexual abuse occurred within the past 96 hours (4 days).
- On the same day if there is vaginal or rectal bleeding, pain, or signs of sexual trauma.
- If the sexual abuse took place more than 96 hours ago, seek the advice of a clinician as needed to determine the urgency of a medical examination on an individual basis. Examples of situations where an immediate exam may be indicated include: the child has vaginal discharge or there is suspicion of a sexually transmitted disease or pregnancy; the child lives in the same house as another child who has been sexually abused; or the child has specific behavioral or physical indicators of sex abuse.

The professional conducting the health evaluation should be trained and experienced in child abuse and child sexual abuse issues. Whether conducted by an individual or a child abuse team, the evaluation should be comprehensive to avoid multiple interviews and examinations, which may increase the trauma for the child. It is recommended that a sexual abuse evaluation take place within a multidisciplinary child abuse team (MDT) or Child Advocacy Center (CAC) (*see section 7, Resources*). If no MDT/CAC is available, a qualified medical professional should conduct the evaluation.

The Child Abuse Evaluation and Treatment for Medical Providers website is a comprehensive source for child abuse information that offers tools and resources with which to diagnose and manage child and adolescent abuse victims: <http://www.childabusemd.com/index.shtml>. Another valuable reference tool for medical practitioners is the Child and Adolescent Sexual Offense Medical Protocol. For an updated version of the protocol, contact the NYS Department of Health's Rape Crisis Program at 518 474-3664. The New York State Children's Justice Task Force Forensic Interviewing Best Practices protocol referenced in the box below is available on the OCFS Intranet at: <http://ocfs.state.nyenet/dps/pdf/NYSCJTFForensicInterviewBestPractice.pdf>.

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### Components of Child Abuse and Neglect Health Evaluation

A medical evaluation for child abuse and neglect should include the following:

1. Interview with the child that is developmentally appropriate, sensitive, and completed in an unbiased and truth seeking manner. The New York State Children's Justice Task Force Forensic Interviewing Best Practices Guidelines are recommended, although not required. With an allegation of sexual abuse, the interviewer also seeks to identify signs and symptoms of child sexual abuse, including but not limited to: nightmares, sexual knowledge inappropriate for the child's age, and sexualized behaviors inappropriate for his/her age (*see Chapter 3, Special Health Care Services, for information on child sexual abusers*).
2. Thorough directed physical examination: observation of verbal and nonverbal behaviors, affect, growth parameters (height, weight), skin, nails, hair, mouth, extremities, genitalia, anus.
3. Documentation, including detailed narrative, sketches, and photographs.
4. Imaging and laboratory studies as clinically indicated: If signs of physical abuse are present, a skeletal survey (x-ray) should be done to identify old and new fractures (e.g., a very young child with injuries in various stages of healing).



### Health Care Coordination Activities

If your county does not have a Child Advocacy Center, identify and use health care practitioners who are experienced and trained in conducting a child abuse and neglect evaluation. Encourage them to reference guidance documents such as the ones noted above. To support a coordinated approach to child abuse and neglect in your local department of social services (LDSS) or voluntary agency, establish a multidisciplinary child abuse team if one is not already present.

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### 7 Resources

#### Medical Home

<http://www.medicalhomeinfo.org/>

The National Center of Medical Home Initiatives for Children with Special Needs is a site sponsored by the American Academy of Pediatrics.

#### Medical Information Sites

##### Fetal Alcohol Spectrum Disorders (FASD)

Any amount of alcohol use by the mother during pregnancy can cause an FASD. Children with an FASD may also be diagnosed with a mental health disorder, have developmental delays and learning problems. Identification of brain damage caused by FASD will assist service providers and schools in implementing effective interventions.

Diagnosis of Fetal Alcohol Syndrome (FAS):

[http://www.cdc.gov/ncbddd/fas/documents/FAS\\_guidelines\\_accessible.pdf](http://www.cdc.gov/ncbddd/fas/documents/FAS_guidelines_accessible.pdf)

New York State: <http://www.oasas.state.ny.us/fasd/index.cfm> (includes additional links)

##### Sickle Cell Disease

The Sickle Cell Information Center: <http://www.scinfo.org/> (includes additional links)

##### Autism Spectrum Disorders

Center for Autism and Related Disabilities: <http://www.albany.edu/psy/autism/autism.html>

National Institute of Mental Health: <http://www.nimh.nih.gov/health/publications/autism/complete-publication.shtml>

#### Immunization Schedule

See the following page for the New York State and New York City Recommended Childhood Immunization Schedule. Check the following website at least once a year for updates to the schedule: [http://www.health.state.ny.us/prevention/immunization/childhood\\_and\\_adolescent.htm](http://www.health.state.ny.us/prevention/immunization/childhood_and_adolescent.htm)

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### New York State Recommended Childhood and Adolescent Immunization Schedule

A check ✓ means that this is the earliest and best time for your child to be immunized. If your child misses the "best time" for vaccination, he or she should still be immunized as quickly as possible. Ask your doctor about getting your child caught up.

Vaccine against:	Age							
	Birth	2 months	4 months	6 months	12 months	18-24 months	4-6 years	11-12 years
Hepatitis A					✓	✓		
Hepatitis B	✓	✓ 1-4 mo.		✓ 6-18 mo.		Recommended for any child not previously vaccinated against Hepatitis B virus.		
Diphtheria, Tetanus, Pertussis (DTaP)	✓	✓	✓	✓	✓ 12-18 mo.	✓		
Haemophilus influenzae type b (Hib)	✓	✓	✓	✓	✓ 12-15 mo.			
Polio (IPV)	✓	✓	✓	✓ 6-18 mo.			✓	
Pneumococcal Disease (PCV7) <sup>1</sup>	✓	✓	✓	✓	✓ 12-15 mo.	Ask your doctor if your child 2 years old or older should get vaccinated with PPV23. <sup>1</sup>		
Measles, Mumps, Rubella (MMR)					✓ 12-15 mo.		✓	
Varicella (Chickenpox)					✓ 12-15 mo.		✓	A second catch-up dose is recommended for any child who has had only one dose.
Rotavirus		✓	✓	✓				
Tetanus, Diphtheria, Pertussis (Tdap)								✓ 11-18 yrs.
Meningococcal Disease (MCV4) <sup>2</sup>						Ask your doctor if your child 7 years old or older should get vaccinated with MCV4. <sup>2</sup>		✓
Human Papillomavirus (HPV)								✓ <sup>3</sup>
Influenza						Recommended yearly for all children aged 6 months and older. Ask your doctor if your child should receive one or two doses.		

<sup>1</sup> PCV7 = Pneumococcal Conjugate Vaccine; PPV23 = Pneumococcal Polysaccharide Vaccine

<sup>2</sup> MCV4 = Meningococcal Conjugate Vaccine

<sup>3</sup> The HPV vaccine is given through a series of three shots over a 6-month period.

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### Mental Health Assessment Tools

#### Voice-Diagnostic Interview Schedule for Children (V-DISC)

V-DISC is a comprehensive, structured interview that uses DSM-IV criteria to screen for more than twenty mental health disorders as well as suicidal ideation found in children and adolescents. The V-DISC is a self-administered test. For more information:

Columbia University - <http://www.promotementalhealth.org/overview.htm>

NYS DPCA: <http://dpca.state.ny.us/technology.htm>

On the following page is a list of instruments used to assess children and adolescents in New York State Office of Mental Health children's programs.

**Note:** Many assessment instruments exist, but not all are valid and reliable. Some are expensive and require training, while others are available at no charge and do not require training. Any tools used for mental health assessment warrant close scrutiny. Please remember that tools are only one aspect of a mental health assessment. Mental health practitioners need to involve the birth family, if possible, the foster family, and schools, along with direct observation.

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### INSTRUMENTS USED TO ASSESS CHILDREN AND ADOLESCENTS IN NYS-OMH CHILDREN'S PROGRAMS

June 2003

Assessment Instrument	Children's Programs	Results of Instrument	Completed By
<b>ASI</b> Adolescent Symptom Inventory - Stonybrook, Ages 13-18 years	Inpatient (Sagamore CPC)	DSM Diagnosis; Symptom Clusters	Parent Teacher
<b>CAFAS</b> Child & Adolescent Functional Assessment Scale	Kids Oneida (Oneida County) SPOA* (1 County)	Level of Functioning; Symptom/Problem Clusters	Trained Rater
<b>CANS-MH</b> Child and Adolescent Needs and Strengths - Mental Health	NYS-OMH Study (statewide) Kids Oneida SPOAs* (most Counties)	Level of Functioning; Level of Need; Symptom/Problem Clusters	Trained Rater
<b>C-DISC</b> Computer Voice - Diagnostic Interview Schedule for Children	Inpatient (Sagamore CPC) School Support III (NYC, 6 sites)	DSM Diagnosis Symptom Clusters	Youth
<b>CSI</b> Child Symptom Inventory - Stonybrook, Ages 6-12 years	Inpatient (Sagamore CPC)	DSM Diagnosis Symptom Cluster	Parent Teacher
<b>SACA</b> Service Assessments for Children and Adolescents	FFT (Functional Family Therapy, 11 teams, 5 locations)	History of Service Use	Trained rater (interviews parent)
<b>SDQ</b> Strengths and Difficulties Questionnaire	FFT (Functional Family Therapy, 11 teams, 5 locations) School Support III (NYC, 6 sites)	Level of Need; Symptom/Problem Clusters	Parent Youth
<b>YI</b> Youth Inventory - Stonybrook, 13-18 years	Inpatient (Sagamore CPC)	DSM Diagnosis; Symptom Clusters	Youth
<b>YDQ</b> Youth Outcome Questionnaire	FFT (Functional Family Therapy, 11 teams, 5 locations)	Outcomes	Parent Youth
<b>YSBI</b> Youth Symptom Behavior Inventory, Child/Adolescent Measurement System	FFT (Functional Family Therapy, 11 teams, 5 locations)	Level of Need; Symptom/Problem Clusters	Parent Youth

\* Single Point of Access.

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### Developmental Assessment Tools

**Ages and Stages Questionnaires** (ASQ and ASQ SE, 1991) are a series of questionnaires that screen and monitor a child's development between 4 months and 5 years of age. The *Ages & Stages Questionnaires® (ASQ): A Parent-Completed, Child-Monitoring System, Second Edition*, is a comprehensive developmental screening tool designed to find out if the child is on track or if he or she should receive a more in-depth assessment to determine the need for specialized services. Developmental areas screened by this measure include: communication, gross motor, fine motor, problem solving, and personal-social; plus self-regulation, compliance, language, adaptive behaviors, autonomy, affect, and interaction with people. The website is <http://www.agesandstages.com/asq/index.html>.

**Battelle Developmental Inventory**, Second Edition (BDI-2, 2005) is designed for use with children between birth and 7 years, 11 months. The assessment can be given up to three times a year, and is available in Spanish. There is both a screening version and an assessment version. The domains covered in the scale include: personal social, adaptive, motor, communication, cognitive.

**Bayley Scales of Infant and Toddler Development**, Third Edition (Bayley-III) can be used to measure development and developmental delays in very young children (ages 1- 42 months). This instrument includes assessment scales for adaptive behavior, cognitive functioning, social-emotional growth, language, and motor skills. Three scales are administered with child interaction, and two with parent questionnaires. The Bayley can be used as a screening tool, a tool to monitor growth or to identify developmental delays, and to determine the need for further in-depth assessment.

The **Prescreening Developmental Questionnaire** (PDQ-II, 1998) has been developed to help parents quickly identify whether their children need further assessment. The PDQ-II is a pre-screening consisting of 91 parent questions. The questionnaires are divided by age range (0 to 9 months, 9 to 24 months, 2 to 4 years, and 4 to 6 years). The website is <http://www.denverii.com/>.

### Measures of Adaptive Behavior

**Adaptive behaviors** are everyday living skills such as walking, talking, getting dressed, going to school, going to work, preparing a meal, cleaning the house, etc. They are skills that a person learns in the process of adapting to his/her surroundings. Since adaptive behaviors are for the most part developmental, it is possible to describe a person's adaptive behavior as an age-equivalent score. An average five-year-old, for example, would be expected to have adaptive behavior similar to that of other five-year-olds. The purpose of measuring adaptive and maladaptive behavior is usually either for diagnosis or for program planning. The diagnosis of mental retardation, for example, requires deficits in both cognitive ability *and* adaptive behavior, occurring before age 18. Adaptive behavior assessment is also used to determine the type and amount of special assistance that people with disabilities may need. This assistance might be in the form of home-based support services for infants and children and their families, special education and vocational training for young people, and supported work or special living arrangements such as personal care attendants, group homes, or nursing homes for adults. Adaptive behavior assessments are often used in preschool and special education programs for determining eligibility, program planning, and assessing outcomes.

**The Adaptive Behavior Assessment Systems**, Second Edition (ABAS II, 2003) is a norm-referenced tool designed to assess the adaptive skills in individuals from birth to 89 years of age

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using 1999-2000 census data. The tool measures the following skill areas: communication, community use, functional academics, home living, health and safety, leisure, self-care, self-direction, social, and work (optional). This measure is a comprehensive tool that assists in the diagnosis and classification of disabilities and medical/clinical disorders, the identification of strengths and weaknesses, service needs for treatment and intervention, and evaluation.

**The Comprehensive Test of Adaptive Behavior-Revised** (CTAB, 2000) is an adaptive behavior assessment measure to precisely evaluate the adaptive abilities of an individual who has a disability from birth. It provides descriptive and prescriptive information for ages 0 to 60 years. It assesses an individual's self-help skills, home living skills, independent living skills, social skills, sensory and motor skills, language concepts, and academic skills.

**Vineland Adaptive Behavior Scales, Second Edition** (VABS-II) is an assessment designed for use to evaluate personal and social skills of children and adults from birth to age 90. It can be used to identify and develop interventions for individuals with a cognitive disability, autism spectrum disorders, attention deficit hyperactivity disorder (ADHD), brain injury, or dementia/Alzheimer's disease. The assessment provides information for developing educational and treatment plans. The item contents reflect tasks and daily living skills that are related to current societal expectations. The content and scales are organized within a three-domain structure (communication, daily living, and socialization) that corresponds to the three broad domains of adaptive functioning recognized by the American Association of Mental Retardation (AAMR, 2002): conceptual, practical, and social. In addition, the assessment includes a motor skills domain and a maladaptive behavior index.

The following document, *Eligibility Assessment Guidelines for B2H Referrals*, provides eligibility guidelines for anyone seeking services through the Office of Mental Retardation and Developmental Disabilities (OMRDD) system and for the Bridges to Health Waiver Program (*see Chapter 3, Special Health Care Services*).

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NYS Office of Mental Retardation & Developmental Disabilities

## Putting People First

### Eligibility Assessment Guidelines for B2H Referrals

A psychological assessment designed to make a differential diagnosis of some form of developmental disability (DD), for inclusion in an OMRDD eligibility packet, must address the key elements of a DD diagnosis. These elements are:

- A. Date of onset (prior to 22 years of age),
- B. Disorder that is **neurologically based** (affects brain and/or spinal cord),
- C. The disorder produces significant adaptive behavior deficits currently and prior to the age of 22,
- D. The condition will last indefinitely.

#### **A. Date of Onset**

1) All developmental disabilities must involve a condition that is **neurologically based** and impacts the person **prior to the age of 22**, and therefore, diagnosis of such a disability requires that a psychologist obtain and present information pertaining to this developmental period. If the person being referred is older than 22, the complete referral packet must include documents supporting the presence of the disability prior to 22. If the person is younger than 22, the psychological must **describe present findings and what has been reported through examination and interview that supports the posited disorder**. For example, for a diagnosis of Autism to be supported, specific descriptions of impaired social relationships, language delay, and stereotypic/compulsive behaviors currently and in childhood, i.e., 2 – 5 years old, must be included to support the diagnosis. If the psychologist examines a person whose circumstance precludes obtaining developmental history, the clinician must state that no history can be obtained, and they must state their judgment regarding the date of onset. They must also address the possibility that events occurring between the age of 22 and the present age could or could not have produced the present deficits.

2) It is possible for a neurological disorder to be present prior to the age of 22, but not produce significant adaptive behavior deficits until after that age. For example, if a seizure disorder is present prior to the age of 22 but relatively well controlled with medication, it may be that the person is developing relatively normally. However, if in their late 20's or 30's the person's seizure disorder significantly worsens, and at that time they present with significant adaptive behavior deficits, they are not considered developmentally disabled.

#### **B. Neurological Disorder**

Aside from the neurologically based disorders that are known by many professionals to be the basis for developmental disabilities (for example, mental retardation, Autism, Cerebral Palsy), there are many obscure conditions that may have to be researched to ensure that they are indeed, neurologically based and not orthopedic or muscular in nature. Evidence of the neurological basis of the disorder is required. However, some non-neurological disorders, for example, osteogenesis imperfecta, may evolve into neurological disorders. If this progression or regression is the basis of the neurological

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disorder that supports a developmental disability diagnosis, a physician must establish this through a consult. It must be reported that the previously non-neurological disorder is now having neurological effects, and these effects have caused significant adaptive behavior deficits prior to the age of 22. Note that psychiatric disorders (depression, anxiety, schizophrenia, bipolar disorder, etc.) are never considered a basis for making a diagnosis of developmental disability even though they may produce similar symptoms at times, and even though most experts agree that anomalies of brain chemistry or structure are the basis of many of these disorders.

### **C. Adaptive Behavior Deficits**

All developmental disabilities must be diagnosed on the basis of the present and past existence of significant adaptive behavior deficits. Regardless of the documented deficits that existed prior to the age of 22, if these deficits no longer exist the person cannot be diagnosed with a developmental disability. Conversely, if significant adaptive behavior deficits are currently present but there is no indication that such deficits existed prior to 22, the person cannot be diagnosed with a developmental disability. A standardized assessment of adaptive behavior must be included in the psychological report\*. Standard scores of each domain must be reported. Age equivalents are not acceptable in place of standard scores. The instrument used for this purpose must be comprehensive, must be normed on an appropriate population, and must be reasonably current such that the normative sample still represents the current population. Assessments of adaptive behavior must be completed with a proper informant. A proper informant is usually a family member or someone who lives with the person. Children under 18 years of age may not be used. In the absence of a family member or someone living with the person, other knowledgeable people are acceptable as informants as long as the lack of availability of anyone else is addressed in the report. On occasion, individuals are assessed who have lived in such isolation much of their lives that there is no proper informant at all. In such cases, this must be stated in the psychological.

\*(OMRDD allows a DDSO to make an exception and not require a formal scale of adaptive behavior for an individual with an IQ below 60. However, "best practices" strongly support inclusion of an adaptive behavior scale for all individuals being referred for eligibility, and failure to do so could result in a request for this to be performed subsequently if the DDSO believes this is needed for a proper determination.)

### **Examples of Appropriate Adaptive Behavior Scales**

- Vineland II Adaptive Behavior Scales
- ABAS (Adaptive Behavior Assessment System)

### **D. Course of Condition**

Some neurological disorders may respond to treatments that significantly reduce the deleterious effects of the condition and prevent the condition from producing the significant adaptive behavior deficits that accompany a developmental disability. For example, treatment of ADHD with medication can have a profound influence on attention and behavior such that a child with ADHD can develop almost normally.

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Similarly, early intervention including speech therapy, PT, and OT can lead to significant improvements in children with PDD NOS or learning disabilities. The psychological report that uses such diagnoses as the basis of a developmental disability must address the likelihood that the condition will last indefinitely even if provided with conventional medical and other treatments. Traumatic brain injuries also present unique assessment issues that must be addressed in the psychological report, particularly in the determination of whether or not the person will likely regain sufficient brain function over time or continue to present with significant adaptive behavior deficits.

### **Cognitive Functioning**

***Mental retardation*** is the only developmental disability that must be diagnosed on the basis of both ***adaptive behavior*** deficits and ***cognitive limitations***. ***A diagnosis of mental retardation therefore absolutely requires the results of an IQ test.*** Nevertheless, OMRDD strongly advises that all eligibility examinations include an IQ test to ensure a proper eligibility determination even if the presenting diagnosis is not mental retardation. The selection of an IQ test must be based on the age and individual needs of each person. However, instruments that are not comprehensive (i.e., the Cognistat, WASI or Slosson) are never accepted. Except for the non-standardized use of the Bayley Scales for individuals with IQ's in the Severe or Profound range of mental retardation, tests may never be translated from English into the person's primary language even if the examiner is fluent in that language.

- **For children whose only language or preferred language is not English, or for nonverbal or deaf children**, the performance items of the Wechsler scales or Stanford-Binet must be used in combination with a language-free instrument such as the \*Leiter-R or C-TONI.
- **For Spanish speaking children**, the new Spanish WISC is acceptable, and if used, obviates the need for use of a language-free instrument.
- **For children and adults whose intellectual functioning is too low for measurement by age-appropriate standardized instruments**, an infant scale should be administered, such as the Bayley III. An IQ and level of mental retardation must still be reported, even if it is an estimate.
- **For children and adults who are extremely difficult to test due to non-compliance, hyperactivity, or inattention**, but who are likely to have IQ's above the Profound or Severe range, it is expected that clinicians will make repeated attempts to obtain a valid test protocol. The Bayley Scales are not to be used in such situations. If these attempts are unsuccessful, the clinician is expected to complete a report with clear statements regarding the difficulties they encountered in attempting to test the individual, and to state any estimate of functioning level they can make with support for their statements. The DDSO eligibility committee will have the discretion to accept the report as submitted and to make their determination with the materials submitted or to request another testing session.
- **For most other children, ages 6 - 16**, the WISC IV or Stanford-Binet V are acceptable instruments.
- **For non-English speaking, deaf, or nonverbal adults**, the performance items of the Wechsler scales or Stanford-Binet must be used in combination with a

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language-free instrument such as the \*Leiter-R or C-TONI in order to determine intellectual functioning.

- **For most other adults**, the WAIS III or Stanford-Binet V are acceptable instruments.

### **Narrative**

Psychological test reports for differential diagnosis and eligibility determination must provide a cogent analysis of past and present test data and history. The purpose of the report is to provide a diagnosis and to support this diagnosis. Therefore, large variations in IQ scores over time, the effects of emotional disturbance or attention on testing, a gross discrepancy between adaptive functioning and measured IQ, peculiar patterns of adaptive functioning, etc. must be addressed in the narrative so that the diagnosis is properly supported.

### **\*Special Testing Considerations**

The **Leiter-R** is an instrument designed for testing people who are nonverbal, do not speak English, or who are deaf. The publisher of the Leiter-R addresses the use of their instrument to diagnose mental retardation in children specifically. They note that "some attempt to measure the client's skills in these (verbal/communication) areas (e.g., in the client's native language) should be pursued to supplement the Leiter-R." However, since the translation of test items into another language does not produce results that can be interpreted via a normative sample, OMRDD has instead emphasized obtaining results of the nonverbal portion of the Wechsler Scales and Stanford-Binet V to supplement the results of the Leiter-R. Except in the case of the Bayley III Scales, OMRDD will not include results of translated tests in its review.

The **Bayley III** is an instrument designed to test infants and toddlers up to the age of 42 months. Although the Bayley III Scales include some verbal items, OMRDD recommends and expects that this instrument be administered in a non-standardized manner for consumers of any age who are too low functioning (and who may lack language) as to make administration of age-appropriate instruments impossible. Therefore, it is not expected that the administration of the Bayley will result in a protocol according to the guidelines of the publisher. Indeed, items may be translated into another language, or it may be necessary to query caregivers as to whether or not the consumer has ever demonstrated the skill being rated if the consumer cannot cooperate for an actual test item. Its use is simply to allow the examiner to make some valid statements regarding the estimated mental age and likely functioning level of the consumer.

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### Substance Abuse Resources

Screening and Assessing Adolescents For Substance Use Disorders  
*Treatment Improvement Protocol (TIP) Series 31*  
(available from: <http://ncadi.samhsa.gov/>. Enter “TIP 31” into Search.)

Excerpts from Chapter 3, Comprehensive Assessment of Adolescents for Referral and Treatment:

Comprehensive assessment follows a positive screening for a substance use disorder and may lead to long-term intervention efforts such as treatment. Screening procedures identify that a youth may have a significant substance use problem. The comprehensive assessment confirms the presence of a problem and helps illuminate other problems connected with the adolescent's substance use disorder. Comprehensive information can be used to develop an appropriate set of interventions.

Listed below are the domains that should be assessed to arrive at an accurate picture of the adolescent's needs or problems:

- History of use of substances, including over-the-counter and prescription drugs, tobacco, and inhalants – the history notes age of first use; frequency, length, and pattern of use; mode of ingestion; treatment history; and signs and symptoms of substance use disorders, including loss of control, preoccupation, and social and legal consequences.
- Strengths and resources to build on, including self-esteem, family, other community supports, coping skills, and motivation for treatment.
- Medical health history and physical examination, noting, for example, previous illnesses, ulcers or other gastrointestinal symptoms, chronic fatigue, recurring fever or weight loss, nutritional status, recurrent nosebleeds, infectious diseases, medical trauma, and pregnancies.
- Sexual history, including sexual orientation, sexual activity, sexual abuse, sexually transmitted diseases (STDs), and STD/HIV risk behavior status (e.g., past or present use of injecting drugs, past or present practice of unsafe sex, selling sex for drugs or food).
- Developmental issues, including possible presence of attention deficit disorders, learning problems, and influences of traumatic events (such as physical or sexual abuse).
- Mental health history, with a focus on depression, suicidal ideation or attempts, attention-deficit disorders, anxiety disorders, and behavioral disorders, as well as details about prior evaluation and treatment for mental health problems.
- Family history (including parents, guardians, and extended family) of substance use, mental and physical health problems and treatment, chronic illnesses, incarceration or illegal activity, child management concerns, and the family's ethnic and socioeconomic background and degree of acculturation. (The description of the home environment should note substandard housing, homelessness, proportion of time the young person spends in shelters or on the streets, and any pattern of running away from home. Issues regarding the youth's history of child abuse or neglect,

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involvement with the child welfare agency, and foster care placements are also key considerations. The family's strengths should be noted as they will be important in intervention efforts.)

- School history, including academic and behavioral performance, and attendance problems.
- Vocational history, including paid and volunteer work.
- Peer relationships, interpersonal skills, gang involvement, and neighborhood environment.
- Juvenile justice involvement and delinquency, including types and incidence of behavior and attitudes toward that behavior.
- Leisure-time activities, including recreational activities, hobbies, and interests.

### CRAFFT Substance Abuse Screening Instrument

Recommended by the American Academy of Pediatrics in its Alcohol Use and Abuse: A Pediatric Concern. See <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/1/185>.

CRAFFT—Questions to Identify Adolescents With Alcohol Abuse Problems* <sup>27</sup>	
C	Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
R	Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
A	Do you ever use alcohol or drugs while you are by yourself, or ALONE?
F	Do you ever FORGET things you did while using alcohol or drugs?
F	Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
T	Have you ever gotten into TROUBLE while you were using alcohol or drugs?

\* Two or more "yes" answers suggest that the adolescent has a serious problem with alcohol or drug abuse.

**Note:** The DAST and MAST are listed below as examples of screening tools.

#### Drug Abuse Screening Test (DAST)

<http://counsellingresource.com/quizzes/drug-abuse/index.html>

The purpose of the DAST is to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and to yield a quantitative index score of the degree of problems related to drug use and misuse. This 20-item instrument may

<sup>27</sup> J.R. Knight, L.A. Shrier, T.D. Bravender, M. Farrell, J. Vander Bilt, H.J. Shaffer. "A new brief screen for adolescent substance abuse," *Archives of Pediatrics & Adolescent Medicine*, 153 (1999), pp. 591-596.

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be given in either a self-report or in a structured interview format. DAST obtains no information on alcohol use, the type of drugs used, or the frequency or duration of drug use.

Michigan Alcohol Screening Test (MAST)

<http://alcoholism.about.com/od/tests/a/mast.htm>

## Child Abuse and Neglect Resources

New York State Child Advocacy Resource  
and Consultation Center (CARCC)

320 Schermerhorn Street

Brooklyn, NY 11217

718-330-5455

866-313-3013 toll free

718-330-5462 fax

<http://www.nyscarcc.org>

Established in 1996 as a program of Safe Horizon, CARCC's mission is to work with Multidisciplinary Teams and Child Advocacy Centers throughout New York State to promote and enhance multidisciplinary responses to child sexual abuse and child fatality reviews (*see website for a list of centers*). This approach maximizes the strength of all disciplines involved in child abuse investigations and minimizes the trauma to child victims. The Center is committed to building on existing resources to benefit multidisciplinary efforts across New York State and to providing services tailored to the needs of each community they serve. CARCC provides periodic regional trainings throughout the year. The New York State Children's Alliance (NYSCA), formed in 1997, is composed of multidisciplinary team coordinators and Child Advocacy Center directors. Contact CARCC to obtain a copy of the NYS Children's Justice Task Force Forensic Interviewing Best Practices protocol. It can also be downloaded from the OCFS Intranet at <http://ocfs.state.nyenet/dps/pdf/NYSCJTFForensicInterviewBestPractice.pdf>.

Child Abuse Evaluation and Treatment for Medical Providers

<http://www.childabusemd.com/index.shtml>

The above website is an online resource for medical providers who do not have a background or expertise in child abuse pediatrics and are striving to develop best practice standards for their patient care setting. It was developed under the direction of Dr. Ann Botash at SUNY Upstate Medical University.

Child Abuse Medical Provider Program (CHAMP)

<http://www.champprogram.com/default.asp>

CHAMP's goal is to improve the New York State medical response to suspected child abuse by improving the examination, treatment, documentation, community referral, and management of suspected child abuse cases.

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American Professional Society on the Abuse of Children

<http://www.apsac.org/mc/page.do>

**Note:** This information is provided for informational purposes only. The NYS Office of Children and Family Services is not responsible for the content.

The American Professional Society on the Abuse of Children (APSAC) is a membership organization for professionals who work in child abuse and neglect. Its mission is to improve the quality of practice provided by professionals who work in child abuse and neglect through:

- Providing professional education that promotes effective, culturally sensitive, and interdisciplinary approaches to the identification, intervention, treatment, and prevention of child abuse and neglect.
- Promoting research and practice guidelines to inform all forms of professional practice in child maltreatment.

Resources include the website, a quarterly newsletter, a quarterly peer-reviewed scientific journal, guidelines (handbook) on child maltreatment, an annual colloquium, training seminars, and state chapters for state-level training and networking.

Child Welfare Information Gateway

<http://www.childwelfare.gov/aboutus.cfm>

Child Welfare Information Gateway promotes the safety, permanency, and well-being of children and families by connecting child welfare, adoption and related professionals as well as concerned citizens to timely, essential information.

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### *Chapter Two*

## Preventive and Ongoing Health Care

To maintain overall health and well-being, children in foster care need ongoing medical assessment, treatment, and services provided in a coordinated, comprehensive manner. This chapter describes the ongoing health services – medical, dental, mental health, developmental, and substance abuse services – that continue the assessment and treatment recommended in the initial comprehensive health evaluation when children are placed in foster care.

Depending on the findings of the initial health evaluation, children in care will differ in their need for health services. While all children must receive routine preventive health care, some will be referred for further assessment and treatment. Others with specific identified conditions or problems will need to receive ongoing treatment.

This chapter outlines the standards for routine preventive health care; health care services; management of medical conditions and chronic illness; and care of acute illness and injury.



Sections in this chapter include:

1. Comprehensive plan of care
2. Routine preventive health care
3. Dental care services
4. Mental health services
5. Developmental services
6. Substance abuse services
7. Management of chronic medical conditions
8. Acute illness and injury/emergency care
9. Resources

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### 1 Comprehensive Plan of Care

Each initial health assessment (i.e., medical, dental, mental health, developmental, and substance abuse) included in the comprehensive health evaluation should result in an individual treatment plan. The plan should address the child's needs identified in each of the assessments and include recommendations for treatment, referral information, and follow-up appointments. The plan should also include information and tips for caregivers about healthy growth and development. The overall health assessment should be included in the child's case planning to enhance service coordination and monitoring.



#### Health Care Coordination Activities

To coordinate the child's treatment, individual treatment plans should be integrated into one comprehensive "plan of care" that formulates how the child's health care needs in every area will be addressed. With an overall plan of care, all providers are aware of the child's various health care issues, medications are managed properly, and casework planning for the child and family incorporates the child's health.

As with any service planning, all those involved with the child should be informed about the plan and have an opportunity to contribute to it. This includes the child's birth parents or prospective adoptive family, as appropriate.

Often foster parents will be responsible for carrying out the plan by accompanying the child to appointments or administering medication. Communicate with the foster parents clearly and consistently to help them understand the child's treatment plan and their role in the plan. This will help them to effectively support and implement the plan.

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## 2 Routine Preventive Health Care

Routine preventive health care promotes the health and well-being of all children. To help achieve optimum preventive health care, each child must have periodic comprehensive medical assessments, also known as well child visits, on an ongoing basis.<sup>1</sup> Even when a child is receiving regular treatment from a specialist for a medical condition (e.g., chronic asthma), well-child visits are necessary as they have a broader scope and purpose.



### Health Care Coordination Activities

Build on the relationship with the primary care provider, which began with the initial health evaluation. You can do this by providing relevant information about the child and your agency, making sure that the child's medical records are up to date, and reinforcing with the foster parents and birth parents how important a "medical home" is both for the child and for their own care of the child. Continue to gather information from the birth parents about the family's and the child's medical history.

## Schedule for Routine Well Child Care

Following the initial medical assessment, periodic well child visits must take place according to the current American Academy of Pediatrics (AAP) *Recommendations for Preventive Pediatric Health Care* schedule, which has been adopted by the New York State Medicaid program. Go to <http://practice.aap.org/content.aspx?aid=1599> for the AAP periodicity schedule. Note that the schedule has been updated since the development of 18 NYCRR 441.22(f). Due to the greater health needs of children in foster care, OCFS recommends additional well-child visits for children under the age of 6. The AAP schedule and the enhanced recommendations for children in foster care are shown below:

Schedule for Well-Child Care	
AAP 2008 schedule (minimum)	Recommended for Foster Care
At age: 4-5 days, 1 month, 2 months, 4 months, 6 months, 9 months	At age: 4-5 days, 1 month, 2 months, 3 months, 4 months, 5 months, 6 months, 9 months
At age: 12 months, 15 months, 18 months, 24 months, 30 months	At age: 12 months, 15 months, 18 months, 24 months, 30 months
At age: 3 years, 4 years, 5 years, 6 years	At age: 3 years, 3 ½ years, 4 years, 4 ½ years, 5 years, 5 ½ years, 6 years
Every year from age 7 to age 21	Every year from age 7 to age 21

Additional visits must occur consistent with current standards for primary care of specific conditions that may be present, e.g., HIV infection, prematurity, cystic fibrosis.

<sup>1</sup> 18 NYCRR 441.22(f) ("periodic individualized medical examinations").

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### Components of Well Child Visits

Well child visits should include:

- Clinical examination by a primary care provider who is a pediatrician, family physician, physician's assistant, or nurse practitioner with pediatric training and experience – preferably, the same provider who conducted the initial medical assessment (the “medical home” for the child).
- Immunizations consistent with current NYS/NYC DOH recommendations for age, with special immunization recommendations for specific conditions that may be present such as HIV infection, sickle cell, asthma, or diabetes. It is important to check the following New York State Department of Health website at least annually for updates to the immunization schedule: [http://www.health.state.ny.us/prevention/immunization/childhood\\_and\\_adolescent.htm](http://www.health.state.ny.us/prevention/immunization/childhood_and_adolescent.htm). (See Chapter 1, *Initial Evaluation of Child's Health*, section 7, *Resources, for the Recommended Childhood Immunization Schedule for New York State*.)
- Periodic screening tests consistent with the current AAP well child visit schedule and DOH regulations for age and current professional standards for specific conditions, e.g., blood tests for lead poisoning.
- Health education and anticipatory guidance consistent with current AAP recommendations for age (see section 9, *Resources*).
- Review and updating of the problem list and treatment plan at each well child visit.

### Follow-Up Activities

To coordinate follow-up after each visit, staff involved with the child's case are responsible for:<sup>2</sup>

- Reviewing the child's medical examination record form to determine whether further treatment is recommended, including referrals and medications.
- Contacting the provider, if necessary, to obtain information on follow-up care and treatment.
- Offering to assist the foster parent with follow-up care and transportation.
- Encouraging the provider to contact the agency about follow-up, referrals, missed appointments, or other important information.

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<sup>2</sup> 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

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### 3 Dental Care Services

Comprehensive dental care for children in foster care includes routine restorative care and ongoing dental examinations, preventive services, and treatment as recommended by the dentist. Follow-up care for all conditions identified in the initial dental assessment is required.<sup>3</sup>

Dental care services include:

- Initial exam, preventive services, and sealants on permanent molar teeth at the time of entry into care.
- Ongoing routine dental care for children age 3 and older [*Note: NYC Administration for Children's Services (ACS) requires an exam by a dentist at age 2*]:
  - Preventive care every 6 months
  - Examination by dentist annually<sup>4</sup>
- Sealants on newly erupted molars at preventive visits.
- Ongoing restorative care to promptly address every problem identified:
  - Timely access to restorative care
  - Fillings
  - Root canals
  - Replace missing and damaged teeth
  - Periodontal care for gum disease
- Immediate access to dentist or oral surgeon for pain or dental trauma.
- Immediate access to effective medication to relieve pain.
- Orthodontics based on NYSDOH Physically Handicapped Children's Program (PHCP) standards for severe handicapping dental conditions (*see section 9, Resources*).

Dental decay can be advanced by 3 years of age. Decay of primary teeth can affect children's growth, lead to malocclusion, and result in significant pain and life-threatening swelling. To prevent cavities in children, high-risk individuals must be identified at an early age, and aggressive strategies should be adopted, including anticipatory guidance, behavior modification (oral hygiene and feeding practices), and establishment of a dental home by 1 year of age for children deemed at risk.<sup>5</sup>

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<sup>3</sup> 18 NYCRR 441.22(g).

<sup>4</sup> 18 NYCRR 441.22(f)(2)(viii).

<sup>5</sup> Oral Health Risk Assessment Timing and Establishment of the Dental Home. 2003. Available at: <http://aappolicy.aappublications.org/>.

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Referral to a dentist and establishment of a dental home is recommended no later than 6 months after the first tooth erupts, or by 12 months of age, whichever comes first. This practice allows the dentist to assess risk and recommend interventions. The dentist can instruct parents and caregivers on oral hygiene for infants and toddlers and make sure the child receives fluoride. It also provides an opportunity for the dentist to intervene in the oral hygiene habits of the primary caregivers to reduce the risk of colonization of the infant by the bacteria that cause tooth decay.

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### 4 Mental Health Services

Children in foster care should receive professional diagnosis, treatment, and services for any mental health needs identified in the initial mental health assessment. Psychiatric, psychological, and other essential services must be made available appropriate to the needs of children in care.<sup>6</sup> The following activities are required:

- Diagnosis and treatment of all identified needs.<sup>7</sup>
- Medically necessary psychiatric and psychological services.<sup>8</sup>
- Care, services, and treatment to ameliorate defects, physical and mental illness, and conditions discovered by Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings.<sup>9</sup>

It is not unusual for children in foster care to experience serious emotional and behavioral issues and be in need of mental health services. Keep in mind that children who do not “act out” may need assistance as much as those who present behavioral challenges. It is important for children to receive mental health services on an ongoing basis, rather than waiting for a crisis to occur. Regular services allow clinicians to form a therapeutic alliance with the child and provide ongoing guidance to caregivers in how to ameliorate or manage crisis situations. Services should be consistent with current professional standards of care for children and adolescents (Practice Parameters of the American Academy of Child and Adolescent Psychiatry) ([www.aacap.org](http://www.aacap.org)) (see section 9, *Resources*).

For information on consent for outpatient mental health services and administration of psychiatric medications, see Chapter 6, Medical Consents, and Appendix B, 08-OCFS-INF-02 The Use of Psychiatric Medications for Children and Youth in Placement – Authority to Consent to Medical Care.



#### Health Care Coordination Activities

Be aware that some psychiatric disorders in children and adolescents (e.g., anxiety, depression) can present with physical complaints or vague somatic symptoms. Examples are sleep and appetite changes, fatigue, decreased energy, pain, headaches, dizziness, palpitations, and shortness of breath. It is important the primary care provider consider emotional problems when evaluating these physical complaints or symptoms. As part of your role to integrate and coordinate the physical and mental health care of children in foster care, provide the guidance to caseworkers and caregivers that emotional and physical problems are often intertwined.

<sup>6</sup> 18 NYCRR 441.15.

<sup>7</sup> 18 NYCRR 508.8(e).

<sup>8</sup> 18 NYCRR 441.15.

<sup>9</sup> EPSDT 5122.E and 5124 A.4 and B.1.

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### Using DSM-IV-TR

A child's mental health assessment may contain terms describing a child's diagnosis and references to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR).<sup>10</sup> The DSM-IV-TR is the manual used by physicians, psychiatrists, psychologists, therapists, and licensed certified social workers to diagnose mental illness (*see section 9, Resources*). This manual spells out the specific diagnostic criteria. When diagnosing a client, the American Psychiatric Association recommends that the clinician use a multiaxial Assessment System, as follows:

- Axis I – Clinical Disorders (i.e., Mental Health)
- Axis II – Personality Disorders and Mental Retardation
- Axis III – General Medical Condition
- Axis IV – Psychosocial and Environmental Factors
- Axis V – Global Assessment of Functioning

Axis I includes all mental health conditions except personality disorders and mental retardation, which are in Axis II; Axis III is used for reporting any major medical conditions that may be relevant to treatment of the mental health disorder; Axis IV is used to report psychosocial and environmental factors affecting the child; and Axis V is the clinician's assessment of the child's overall level of functioning.

### Components of Mental Health Treatment

In general, management of identified mental health needs includes mental health intervention/treatment services; development of a mental health crisis plan; periodic review and revision of the individual treatment plan; and periodic re-evaluation of the child (*see section 9, Resources*).

It is helpful for the caseworker, foster parents, and birth parents to know what to expect when a child receives mental health evaluation and treatment. Issues they may have to deal with include the kind of counseling or therapy recommended, medication, and other interventions such as family support or respite services. The more information they have about such approaches the better equipped they will be to support them.

Mental health treatment services include various therapeutic approaches to individual and family counseling:

- Using verbal psychotherapy, commonly known as “talk therapy,” the therapist meets with the child in individual or family sessions.
- In interactive psychotherapy, commonly known as “play therapy,” the child explores issues with the therapist through play with toys or other items designed for this purpose.

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<sup>10</sup> American Psychiatric Association, Arlington, VA, 2000.

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- With cognitive-behavioral therapy (CBT) for children, the therapist helps the child see the connection between his/her thinking and behavior.
- Group therapy is commonly used, especially psychosocial or psycho-educational groups. Adolescents in particular may not respond well to individual therapy and may be more expressive with peers in the group therapy setting.

Additional types include dialectical behavior therapy (DBT), family therapy, interpersonal therapy (IPT), psychodynamic therapy, behavior therapy, and expressive therapies (e.g., art and music). Depending on the diagnosis, psychiatric medication may be prescribed along with psychotherapy or other individual or group services (*see Chapter 5, Medication Administration and Management*). Additional related treatment may include substance abuse treatment services, when needed.

Flexible wrap-around services are an essential component of individualized, community-based care for children and adolescents with SED (Serious Emotional Disturbance). These services are flexible, and child/family-focused. The services follow or “wrap around” the child or adolescent to facilitate return to optimal functioning at home and in the community. Examples include afterschool programs, summer camp, recreation programs, mentoring, life coaches, and community supervision.

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### 5 Developmental Services

Children in foster care often experience problems in growth and development resulting from growing up with abuse, neglect, and family substance use as well as other factors such as premature birth and poor prenatal and infant health care. Developmental services for children in foster care include timely access to services identified in the initial medical or developmental assessments and age-appropriate assessment at routine periodic medical visits.

It is recommended that each well child visit include an assessment of the child's developmental, educational, and emotional status based on an interview with the foster parents, standardized tests of development, and/or review of school progress. Children at known risk for developmental delay, including those born prematurely, those born to mothers with alcohol or substance abuse problems, and all HIV-infected children, should have formal developmental assessments at regular intervals to identify developmental delays as early as possible.

Developmental services include the diagnosis and treatment of all developmental delays and deficits identified and developmental treatment services such as speech and language therapy; occupational therapy; physical therapy; and services for the hearing and visually impaired.

There are several routes to access developmental services depending on the child's age:

- Early Intervention Program (up to age 3) through referral to the local EI Officer for evaluation and services.
- Preschool Special Education (ages 3-5) through referral to the local school district or regional preschool special education program for evaluation and services.
- Special Education (ages 5-21) through referral to the local school district or regional special education programs for evaluation and services.
- Section 504 (Education Law) (ages 5-21) services for general education students.

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### Health Care Providers and Other Professionals

In addition to health practitioners, other professionals who may be involved in the assessment or treatment of children and adolescents in foster care may include:

- Speech and language pathologists with training and/or experience in child speech pathology.
- Physical and occupational therapists with training and/or experience in the motor problems of children.
- School psychologists.
- Certified family therapists.
- Certified arts therapists (art/music/dance).

## Early Intervention Program

Children ages birth through three years may be eligible for participation in the Early Intervention (EI) Program because they are experiencing developmental delays or disabilities. The Early Intervention Program is a voluntary program offering a variety of therapeutic and support services to eligible infants and toddlers and their families.

If parents are the subject of an indicated child protective report and have a child under the age of three, the local social services districts must inform the parents of the EI program and refer them to the county EIP. If the child is in foster care, the foster care agency must initiate a screening or referral to the EIP (*see Appendix B, 04-OCFS-LCM-04*).

The EI Program is administered locally in each of the 57 counties and New York City. An Early Intervention Official/Designee (EIO/D) in each municipality is responsible for identifying eligible children and ensuring that EI services contained in the family's Individualized Family Service Plan (IFSP) are delivered. Most EIOs are directors or commissioners of county health departments. The New York State Department of Health is the lead state agency responsible for the Early Intervention Program (*see Appendix D for the Protocol: Children in Foster Care Who Participate in the Early Intervention Program*).

The following services can be included in the IFSP: assistive technology devices and services, family training and counseling, home visits, parent support groups, special instruction, speech-language pathology and audiology, occupational therapy, physical therapy, psychological services, service coordination, nursing services, nutritional services, social work services, vision services, and transportation-related costs necessary to enable a child to benefit from other EI services while the child is receiving these services.

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To be eligible for services, children must be under 3 years of age and have a disability or developmental delay. In New York State, children must meet the eligibility criteria to receive EI services. The EI Officer is responsible for identifying, tracking, and periodic developmental screening of children at risk of developmental delay or using available resources. Although the program is voluntary, under certain circumstances there may be a court order requiring that EI services be provided.

The EI Program requires the appointment of a “surrogate parent” to assume the responsibilities of a birth parent/guardian when a child in foster care is eligible for EI services and is either a ward of the state – i.e., in the custody and guardianship of the local commissioner of social services – or is not a ward of the state but whose birth parent/guardian is unavailable. The EI Officer should designate the foster parent or an appropriate and available relative as the surrogate parent for the EI Program.

Regarding consent for EI services, note that although the LDSS commissioner can generally consent to medical, dental, and hospital services for children who are in the commissioner’s custody, the Individuals with Disabilities Education Act (IDEA) specifically excludes state officials from acting as a surrogate parent in the EI Program (*see Chapter 6, Medical Consents, for detailed information on consent for Early Intervention services*).

### Caseworker and EI Program: Working Together

Professionals working in the Early Intervention Program and the local district must communicate and work together when involved with the same child and family. Once a child in foster care has been deemed eligible for EI services, it is important that the EI Program inform the caseworker about the child’s EI status, service plan, and progress so that the local district can more effectively carry out its responsibilities for general management of the child’s foster care program, taking into account what is happening to the child while he/she is receiving EI services.

At the same time, it is important for the caseworker to keep the EI Program up to date about the child’s placement, location, health and medical status, and social services status. Ongoing awareness of the child’s whereabouts and foster care status will allow the local EI Program to develop and implement a supportive, appropriate service plan and to appropriately claim and receive reimbursement from the state program.

Regarding EI services, the caseworker is responsible for the following:

- As a primary referral source, identifies and refers children under the age of three who were part of an indicated child protective report or are at risk of having a disability to the program.
- Participates in IFSP development.
- Documents the outcome of all IFSP meetings in the case record and ties this information to permanency planning and planning for other services.
- Considers early intervention services when coordinating permanency planning and other services.

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- Shares basic information about the EI Program with birth parents and foster parents.
- If the foster parents did not participate in IFSP development, notifies them of how the plan will be implemented and their obligations when EI services are being delivered.
- Coordinates with the EI Officer to transition child into preschool special education or other services as appropriate as child's third birthday approaches.

➔ **See Appendix D for the Protocol: Children in Foster Care Who Participate in the Early Intervention Program.** The protocol outlines the responsibilities and procedures for the LDSS caseworker regarding identification of children eligible for the Early Intervention Program, referral to the program, intake, evaluation, IFSP, delivery of services, mediation, and transition and discharge.



### Health Care Coordination Activities

Designate an LDSS Early Intervention program liaison. Urge local districts and local Early Intervention Programs to collaborate and develop a general consent form that will meet both system requirements and facilitate sharing of information. Encourage staff to attend state-sponsored training on EI services. Help develop an interagency agreement between the municipal EIP and LDSS to address the referral process of children transitioning from the EI Program to preschool special education.

## Transition from EIP to Preschool Special Education

If a child has been determined eligible for Early Intervention programs and services, the child can transition smoothly into preschool special education services. If the child is referred to the Committee on Preschool Special Education (CPSE) and determined eligible for preschool special education programs and services, early intervention services may continue past the child's third birthday as follows:

- Children who turn three years of age between January 1<sup>st</sup> and August 31<sup>st</sup> are eligible to continue to receive early intervention services until September 1<sup>st</sup> of the calendar year.
- Children who turn three years of age between September 1<sup>st</sup> and December 31<sup>st</sup> are eligible to continue to receive early intervention services until January 2<sup>nd</sup> of the following calendar year.<sup>11</sup>

If the child is not referred to the CPSE and determined eligible for preschool special education programs and services, early intervention services will end at the child's third birthday.<sup>12</sup>

The Early Intervention Official (EIO) is required, with consent of the parent or surrogate parent, to notify the school district of the child's potential transition to preschool special education at least 120

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<sup>11</sup> Public Health 2541(8)(a).

<sup>12</sup> Public Health 2541(8)(b).

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days before the date of the child's first date of eligibility.<sup>13</sup> The EIO must also convene a transition conference at least 90 days before the child's first date of eligibility for preschool special education.<sup>14</sup>

### Preschool Special Education Services

Children ages 3 to 5 who have not transitioned from EIP to preschool special education and are suspected of having a disability that may affect their school performance may also be referred for services. A written referral for an individual evaluation and determination of eligibility for special education programs and services should be sent to the Chairperson of the Committee on Special Education (CSE) or Committee on Preschool Special Education (CPSE) or to the building administrator in the school district where the child is placed.<sup>15</sup> The CPSE is responsible for evaluating all students referred and placing all those in need of special education. If the evaluation determines that the child is in need of special education, an individualized education plan (IEP) will be developed for the child.

To be identified as having a disability, a preschool child has either a significant delay or disorder in one or more functional areas related to cognitive, language and communicative, adaptive, socio-emotional or motor development which adversely affects the child's ability to learn, or meets the criteria for: autism, deafness, deaf-blindness, hearing impairment, orthopedic impairment, other-health impairment, traumatic brain injury, or visual impairment.



#### Health Care Coordination Activities

Develop a list of schools approved to conduct initial evaluations of preschool students in your county and surrounding counties and the procedures that must be followed to select one of the approved evaluators to conduct the initial evaluation on the child. Assist the foster parents in obtaining the evaluation.

### Special Education Services

A student suspected of having a disability must be referred in writing to the Chairperson of the Committee on Special Education (CSE) or to the building administrator of the relevant school district.<sup>16</sup> The CSE is responsible for evaluating all students referred and placing all those in need of special education. If the evaluation determines that the child is in need of special education, an individualized education plan (IEP) will be developed for the child.

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<sup>13</sup> Public Health 2514(14).

<sup>14</sup> 10 NYCRR 69-4.20(b).

<sup>15</sup> *Individual Evaluations and Eligibility Determinations for Students with Disabilities*, New York State Education Department, Office of Vocational and Educational Services, revised January 2002.

<sup>16</sup> *Ibid.*

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Special Education services cover a range of services and settings. In addition to modified and specialized instructional services provided in self-contained classes and special schools, special education students may receive developmental treatment services in regular schools. The CSE coordinates with the therapists, arranges placement and transportation services, and evaluates students who are not attending public schools (e.g., preschool, private/parochial). A CSE includes clinical supervisors who supervise psychologists, social workers, education evaluators, and other school personnel.

A student with a disability means a student who is entitled to attend public schools and who, because of mental, physical, or emotional reasons, has been identified as having a disability, including: autism, deafness, deaf-blindness, emotional disturbance, hearing impairment, learning disability, mental retardation, multiple disabilities, orthopedic impairment, other-health impairment, speech or language impairment, traumatic brain injury, or visual impairment including blindness.



### Health Care Coordination Activities

Encourage birth parents and foster parents, as well as casework staff, to attend the periodic CSE meetings that evaluate the child's progress and treatment plan. Attending the meetings provides a way to learn about the services the child is receiving and an opportunity to contribute information about the child and to advocate for the child's needs.

## Section 504 Services for Children in General Education Classes

Section 504 of the Rehabilitation Act of 1973 makes it possible for students with certain special needs to remain in a general education class. Section 504 establishes that disabled or "medically fragile" students, whose impairments do not directly limit their ability to learn, have a right to a free, appropriate public education. School districts have to provide the necessary educational services, aids, and accommodations to ensure this right. Certain types of schools (e.g., Union Free and 853 schools) provide Section 504 services on site.

If possible, students should be in a general education school program and fully take part in all the activities of the class. Section 504 requires that students with special needs due to physical and mental impairment be accommodated in the least restrictive educational environment. Such services and aids should be delivered in a way that does not stigmatize the student.

Adjustments or services may include (1) modifications to a student's general education program, such as preferential seating, alternative testing techniques, classwork/homework modifications, barrier-free placement, bus transportation, an elevator pass, and counseling; and (2) provision of certain health-related services to help the student attend school, such as monitoring the administration of oral medication and the use of inhalers; monitoring of blood sugar levels; injections; clean intermittent catheterization; and emergency administration of medication.

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Examples of protected students are children with asthma, diabetes, allergies, cerebral palsy, cancer, HIV-related illnesses, epilepsy, dyslexia, and spina bifida.

Children in foster care will either be referred from the CSE to Section 504 services, or by the agency as a result of the developmental assessment. Upon request for services, the evaluation by the school will determine if the student has a mental or physical impairment; if the impairment substantially limits one or more of the student's major life activities; and if the student is a qualified disabled student within the meaning of Section 504.

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### 6 Substance Abuse Services

Children in foster care should be screened for a family history of alcohol and drug use, a history of their own use, and other risk related behaviors. The screen for individuals age 13 and older should be part of the comprehensive health evaluation that is completed when a child is placed. Youth of any age who are identified as having alcohol or/other drug related problems should receive professional services that include a comprehensive assessment for alcohol and substance abuse disorders based on DSM-IV-TR diagnosis. Treatment and services for any alcohol or drug abuse problem identified as part of the screening and assessment process should be provided in accordance with the current standard of care for adolescents (*see section 9, Resources, for Treatment of Adolescents With Substance Use Disorders*).

**Note:** “Substance” or “drug” includes all alcohol and chemicals improperly used either by inhalation, smoking, ingestion, or injection. The terms “chemical dependence” or “chemical abuse” may also be used by clinicians and treatment providers. The difference between dependence and abuse is explained in the definitions below:<sup>17</sup>

- Substance abuse is characterized by a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. In order for an abuse criterion to be met, the substance related-problem must have occurred repeatedly during the same 12-month period or been persistent.
- Substance dependence is characterized by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive [substance]-taking behavior.

### Drug Screening

OCFS recommends the use of urine drug testing for children in foster care only in one or more of the following circumstances:

- A court has ordered such screening or testing.
- The child has consented to such screening or testing as a condition of participation in an approved (licensed) substance abuse treatment program.
- A clinician or certified alcohol and substance abuse counselor (CASAC) has directed that testing be done as part of the child’s services/treatment plan to determine if the child is using a substance that may present a risk to the child’s health and safety. The clinician or CASAC should oversee the testing protocols.

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<sup>17</sup> DSM-IV-TR.

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- The clinician or CASAC has reasonable cause to suspect that the child is unlawfully under the influence of a drug or controlled substance, and the executive director of the authorized agency or his or her designee has approved of the testing. Reasonable cause to suspect should be based on specific, reliable observations that can be articulated, not solely upon information received from other children or anonymous sources, and should be documented in the child's case record.

A screening may show that a child is at risk or already has alcohol or substance abuse problems. Whenever possible, refer children to programs licensed by the New York State Office of Alcohol and Substance Abuse Services (OASAS). These programs provide preventive and treatment services in a variety of settings (*see section 9, Resources*).



### Health Care Coordination Activities

Make sure that your agency has the OASAS Provider Directory available for staff who make referrals (*see section 9, Resources*). The directory lists providers by county and identifies program type (e.g., crisis services/medically monitored withdrawal; chemical dependency youth/outpatient) as well as contact information. To achieve continuity of substance abuse services when children are discharged from foster care, refer them to OASAS school-based student assistance programs, where available. Also, learn which schools in your community have programs on alcohol and substance abuse. Many schools have a school-based prevention/intervention program, which offers a curriculum and instruction for staff and assistance for youth in crisis.

## Training for Staff, Caregivers, and Health Care Providers

Topics for staff and caregiver training on the impact of substance abuse on children and adolescents should include detecting substance abuse and procedures for handling emergencies. Staff and foster parents should be familiar with and alert to behaviors that may be signs of substance abuse. These include disorientation, confusion, euphoria, auditory and visual hallucinations, delusions, distorted sensory perception, drowsiness, lack of coordination, feelings of detachment, incoherent speech, disruption of thought processes, and unconsciousness. Pronounced pinpoint pupils of the eyes and needle marks on the arms and other parts of the body are probable physical signs indicative of drug use.

## Methamphetamine

Methamphetamine (meth) is a powerfully addictive drug of abuse with an added risk: clandestine manufacture in homes, outbuildings, and even vehicles. The chemicals found in clandestine laboratories can damage the respiratory tract, mucous membranes, eyes, and skin. Some of the chemicals can produce a fire or explosion. Meth production contaminates surfaces such as walls, floors, counters, and children's toys and clothing. If a child found at a meth lab shows signs of exposure such as respiratory distress, eye irritation, chemical residue, or obvious injury, seek immediate medical attention. See section 9, Resources, for more information.

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Immediately leave the scene and contact law enforcement if you encounter what you believe is a clandestine laboratory. Inform law enforcement if you believe children are present. Be aware that some meth producers may set booby traps at the site to deter authorities. OCFS provided teleconference training on methamphetamine and worker safety on March 26, 2006. Copies are available from the OCFS library. This training is recommended for all staff. Contact your staff development coordinator for more information.

All mandated reporters of suspected child abuse or maltreatment who travel to children's homes must be informed by their employer of the signs of a clandestine methamphetamine laboratory.<sup>18</sup> A brochure with this information can be downloaded from the Office of Alcoholism and Substance Abuse (OASAS) Methamphetamine Clearinghouse at <http://www.oasas.state.ny.us/meth/index.cfm>. The brochures should be printed in color to obtain the full benefit of the lab photographs.



### Health Care Coordination Activities

Be familiar with your agency's procedures for drug-related emergencies, which should be handled quickly and properly. Depending on the child's particular behaviors and symptoms, staff may need to have the child transported by ambulance to a hospital or take other actions to monitor the situation. Observe for signs of respiratory distress, avoid rough handling, and provide comfort and reassurance.

At the same time, health care providers of substance abuse services should receive training on the broad health needs of children in foster care. If your agency has ongoing relationships with specific providers, it should make this type of training available for them.

## Engaging and Counseling Children

Children may not want to recognize or acknowledge that they have a substance abuse problem. Persuading the child or youth that they need services may be the first challenge faced by staff in dealing with substance abuse. Some tips for initial engagement include:

1. Review the child's health record, including the extent of substance abuse problems and risk behaviors.
2. Establish an atmosphere of trust and confidence with the child, birth parents, foster parents, and staff. Support a "no blame" approach.
3. Interview the birth parent and foster parent to determine whether there is a need for assessment and referral for substance abuse services.
4. Interview the child privately to determine the extent and nature of the child's substance abuse problem.

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<sup>18</sup> SSL 413.4.

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5. Prepare the child for referral and assess readiness to engage in treatment.

If it is not time for a regularly scheduled Service Plan Review, call a case conference to discuss the situation and develop a plan for services and follow-up. The meeting should be conducted in such a way that the child, birth parent (if present), and foster parent are not frightened by the information, but at the same time the problem is not minimized.

### Tobacco Use

Public health law states that smoking is not allowed in group homes, public institutions, youth centers and facilities for detention.<sup>19</sup> The known effects of second-hand smoke should be carefully considered when selecting a foster home for children. Local districts and voluntary agencies should avoid placing very young, allergenic, or asthmatic children in homes where one or more residents smoke. Foster parents should be advised to:

- Limit smoking in their homes to the extent possible.
- In particular, avoid smoking in all areas where a foster child sleeps, eats, and/or spends a lot of time.
- Avoid smoking in vehicles, especially when transporting foster children.
- Be extra diligent in avoiding exposing very young, allergenic, or asthmatic children to second-hand smoke.<sup>20</sup>

Case planners and foster parents should actively discourage foster children from smoking or continuing to smoke. They must not assist the foster child in purchasing or obtaining cigarettes. Foster parents are on firm ground in preventing a foster child from smoking in their home.<sup>21</sup>

Agencies should offer prevention education programs to educate children and youth on the harmful effects of smoking and other tobacco use. They should also provide smoking cessation treatment for children and youth who smoke.

**Note:** It is illegal for children under the age of 18 to buy tobacco products (e.g., cigarettes, cigars, chewing tobacco).

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<sup>19</sup> PHL Article 13-E, 1399-o.

<sup>20</sup> 04-OCFS-INF-05.

<sup>21</sup> Ibid.

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### 7 Management of Chronic Medical Conditions

Many children in foster care experience serious, chronic medical conditions that need ongoing treatment and monitoring (e.g., asthma, diabetes, skin problems, seizures, vision and hearing problems, and chronic infectious diseases). Ongoing, primary health care includes the management of such conditions.

When a child has a chronic illness or condition requiring long-term medical, mental health, dental, or other services, a treatment plan should be developed detailing the proposed treatment, alternative treatments, and risks/benefits. Staff should make reasonable efforts to engage the birth parent and obtain informed consent for the treatment plan.

Health care coordination activities necessary to effectively manage these situations include:

- Treatment planning – to coordinate treatment between primary care and specialty care providers.
- Specialty referrals for conditions that cannot be fully managed by a primary care provider.
- Follow-up care for any conditions identified as recommended by the primary care provider.<sup>22</sup> Periodic visits should occur at a frequency consistent with current professional standards for management of specific conditions – usually at least every three months when the child with chronic illness is stable and doing well.
- Multidisciplinary approach for children with complex chronic medical, mental health, and behavioral problems.

Provide or arrange for diagnostic and treatment services for conditions identified during a comprehensive medical evaluation (*see Chapter 3, Special Health Care Services*). If a finding requires more extensive diagnosis and/or treatment than is immediately available, schedule an appointment for these services without delay.

**Note:** Institutions must provide glasses, hearing aids, and prosthetic or other adaptive devices when needed.<sup>23</sup>

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<sup>22</sup> 18 NYCRR 441.22(g).

<sup>23</sup> 18 NYCRR 442.21(g).

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### 8 Acute Illness and Injury/Emergency Care

Comprehensive health care includes treatment for acute illness and injury. At a minimum, make sure that children experiencing an acute illness or injury receive the following:

- Timely access to appropriate health professional services.
- After hours (24 hours a day) advice and care which is available and accessible.
- Medications:
  - Prompt access to prescribed medications.
  - Administration as ordered by the health practitioner.
  - Monitoring and accountability for proper administration.
  - In congregate care facilities, routine documentation of medical administration.

### Emergency Procedures

Agencies must inform foster parents of procedures for obtaining care for suspected illness or medical emergencies.<sup>24</sup> This includes providing an after-hours or emergency contact list. In foster parent training, handbooks, and case contacts: (1) cover what constitutes an emergency, and (2) inform foster parents of procedures for calling “on-call” staff or going to the emergency room (*see Chapter 10, Supporting Caregivers, for tips and a sample fact sheet on emergencies for foster parents*).

Emergency rooms are to be used only in the following situations:

- When medically necessary.
- When no other 24-hour care is available.
- When injuries indicate the need.
- When hospitalization is recommended.

### Communicable Diseases and Schools

Schools are responsible for carrying out policies to temporarily exclude students from school if they have certain communicable and/or infectious diseases. Schools follow the recommendations of the federal Centers for Disease Control (CDC) and the local health department. The principal has the final responsibility to isolate the student with suspected communicable disease and to notify the foster

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<sup>24</sup> 18 NYCRR 441.22(j)(i)(ii) and (iii). In New York City, a form W-853D must be completed to begin an investigation into serious accidents, incidents, illnesses, injuries, and deaths (including suicides) that “do not rise to the level of a child abuse/neglect report acceptable to the New York State Central Register.”

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parent to remove the student from school. If the student is acutely ill and the foster parent or caseworker cannot be reached to remove the child from school, the principal arranges for the removal of the student to a hospital.

Schools generally have exclusion policies for the following communicable diseases:

- chickenpox (varicella)
- pink eye (conjunctivitis)
- beaver fever (giardiasis)
- hand, foot and mouth disease
- Coxsackie virus
- hepatitis A
- impetigo
- infectious mononucleosis
- measles (rubeola)
- meningitis
- mumps
- head lice (pediculosis)
- German measles (rubella)
- scabies
- streptococcal infection (sore throat, scarlet fever)
- shigellosis (bacillary dysentery)
- whooping cough (pertussis).<sup>25</sup>



### Health Care Coordination Activities

Caregivers should also be familiar with the school's exclusion policies on communicable diseases. A checklist for conditions that are contagious and require staying away from school would be helpful for foster parents. Check with the schools in the community to see if they provide a list of such conditions and illnesses to parents, what the rules are for returning the child to school, and opportunities for the child to continue studies with work sent home.

<sup>25</sup> Bureau of Communicable Disease Control, New York State Department of Health, April 1996.

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### 9 Resources

#### Health Guidance Materials

##### American Academy of Pediatrics (AAP)

The AAP publishes a wealth of information for practitioners on topics ranging from nutrition to mental health to adolescent health and sexuality. Go to [www.aap.org](http://www.aap.org). Click on Member Center, then select Policy Statements/Practice Guidelines. The Bookstore & Publications link offers additional materials, including Fostering Health, recommended for all clinicians treating children in foster care.

##### Bright Futures

Bright Futures, <http://www.brightfutures.org/>, is a national health promotion and disease prevention initiative that addresses children's health needs in the context of family and community. The centerpiece of Bright Futures is a comprehensive set of health supervision guidelines developed by multidisciplinary child health experts – ranging from providers and researchers to parents and other child advocates – that provide a framework for well-child care from birth to age 21. These guidelines are designed to present a single standard of care and a common language based on a model of health promotion and disease prevention.

*Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents—Third Edition* (2008) combines the authoritative *AAP Guidelines for Health Supervision III* with the practical approach used by Bright Futures. Chapters can be downloaded from: [http://brightfutures.aap.org/3rd\\_Edition\\_Guidelines\\_and\\_Pocket\\_Guide.html](http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html); or the materials can be purchased from the AAP Bookstore at [https://www.nfaap.org/netFORUM/eweb/DynamicPage.aspx?webcode=aapbks\\_productdetail&key=68eca6db-7d0d-4ffd-b264-a334b9876ea6](https://www.nfaap.org/netFORUM/eweb/DynamicPage.aspx?webcode=aapbks_productdetail&key=68eca6db-7d0d-4ffd-b264-a334b9876ea6).

The *Guidelines* are organized as follows:

**Part 1** features 10 chapters on key themes that recur in each stage of child development.

**Part 2** provides health supervision guidance and anticipatory guidance for the 31 recommended health supervision visits from infancy through late adolescence. Each visit:

- Starts with a context that captures the child at that age.
- Contains handy lists and tables that summarize interval history questions, parent-child and developmental observation, physical exam, medical screening, and immunizations.

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- Lists five priorities that help you focus your discussions with parents and children on the most important issues for that visit.
- Provides anticipatory guidance for each priority with sample questions and discussion points.

### Healthy People 2010

*Healthy People 2010* is a comprehensive set of disease prevention and health promotion objectives for the Nation to achieve over the first decade of the new century. Created by scientists both inside and outside of Government, it identifies a wide range of public health priorities and specific, measurable objectives. Its overarching goals are to: (1) increase quality and years of healthy life; and (2) eliminate health disparities. The website is <http://www.healthypeople.gov/>.

The 28 focus areas of Healthy People 2010 were developed by leading federal agencies with the most relevant scientific expertise. The development process was informed by the Healthy People Consortium—an alliance of more than 350 national membership organizations and 250 state health, mental health, substance abuse, and environmental agencies. In addition, through a series of regional and national meetings and an interactive website, more than 11,000 public comments on the draft objectives were received. The Secretary's Council on National Health Promotion and Disease Prevention Objectives for 2010 also provided leadership and advice in the development of national health objectives.

Individuals, groups, and organizations are encouraged to integrate Healthy People 2010 into current programs, special events, publications, and meetings. Businesses can use the framework, for example, to guide worksite health promotion activities as well as community-based initiatives. Schools, colleges, and civic and faith-based organizations can undertake activities to further the health of all members of their community. Health care providers can encourage their patients to pursue healthier lifestyles and to participate in community-based programs. By selecting from among the national objectives, individuals and organizations can build an agenda for community health improvement and can monitor results over time.

Following are examples of nutrition and physical activity objectives for children and youth:

- Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardio-respiratory fitness three or more days per week for 20 or more minutes per occasion.
- Reduce the proportion of children and adolescents who are overweight or obese.
- Increase the proportion of persons age 2 and older who consume 2,400 mg. or less of sodium daily.
- Increase the proportion of persons age 2 and older who meet dietary recommendations for calcium.

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- Reduce iron deficiency among young children and females of childbearing age.
- Reduce noise-induced hearing loss in children and adolescents age 17 and under.

## Dental Services

### Orthodontia

**Orthodontia is covered under Medicaid for children with severe handicapping dental conditions.** The child's basic dental needs will need to be met by their primary dentist prior to the initiation of the referral to the orthodontist. Teeth that are in need of cleaning or fillings should be taken care of and good oral hygiene established.

Outside of NYC, a dentist refers the child to an orthodontist to determine if treatment is needed. If families or providers need assistance locating a dentist or an orthodontist who will accept Medicaid or PHCP, they should call the Growing Up Healthy Hotline at 1-800-522-5006. The orthodontist screens the child, and sends in a request for prior approval of treatment to the NYS Department of Health.

In NYC, the dentist or foster care staff should call 212-788-5538 at the NYC Department of Health to request a referral to an orthodontist that accepts Medicaid. As above, the orthodontist screens the child and sends in a request for prior approval of treatment to the NYS Department of Health.

### National Maternal and Child Oral Health Resource Center

The purpose of the National Maternal and Child Oral Health Resource Center (OHRC) is to respond to the needs of states and communities in addressing current and emerging public oral health issues. OHRC supports health professionals, program administrators, educators, policymakers, and others with the goal of improving oral health services for infants, children, adolescents, and their families. The resource center collaborates with federal, state, and local agencies; national and state organizations and associations; and foundations to gather, develop, and share high-quality information and materials. <http://www.mchoralhealth.org/default.html>

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### Mental Health Services

New York State Office of Mental Health

<http://www.omh.state.ny.us/>

The American Academy of Child and  
Adolescent Psychiatry (AACAP)

The AACAP has published over 25 Practice Parameters. The Parameters are published as Official Actions of the AACAP in the *Journal of the American Academy of Child and Adolescent Psychiatry*. The AACAP Practice Parameters are designed to assist clinicians in providing high quality assessment and treatment that are consistent with the best available scientific evidence and clinical consensus. The Parameters may be downloaded from the website: <http://www.aacap.org/>. Click on Physicians and Allied Professionals, then Practice Information, then Practice Parameters.

Bright Futures Mental Health Guide

The information and resources in Volume 1 provide primary care health professionals with the tools needed to promote mental health in children, adolescents, and their families. It also helps them recognize the early stages of mental health problems and mental disorders, and be able to intervene appropriately. Volume 2 is a tool kit that provides hands-on tools for health care professionals and families for use in screening, care management, and health education.

Website: [http://brightfutures.aap.org/practice\\_guides\\_and\\_other\\_resources.html](http://brightfutures.aap.org/practice_guides_and_other_resources.html). This guide is endorsed by the National Institute for Health Care Management (NICHM), [www.nihcm.org](http://www.nihcm.org).

DSM-IV-TR

To obtain a copy of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Revision, Text Revision (DSM-IV-TR), go to the American Psychiatric Publishing, Inc. website at <http://www.appi.org/>. You can learn more about the DSM at <http://www.dsmivtr.org/2-1faqs.cfm>.

National Alliance on Mental Illness (NAMI)

NAMI, the nation's largest grassroots organization for people with mental illness and their families, is dedicated to the eradication of mental illnesses and to the improvement of the quality of life for persons of all ages who are affected by mental illnesses. Their website, <http://www.nami.org/>, contains descriptions of mental health disorders and comprehensive information on medications used to address symptoms. The Helpline is 1-800-950-6264.

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### Types of Preventive Mental Health Services

Preventive mental health services include universal, selective, indicated, and prevention-minded treatment:

- *Universal prevention* is targeted to the general population or whole population of a specific eligible group but is not identified on the basis of individual risk. Examples include adequate diet, seat belts, prenatal care, conflict negotiation training for kindergarten children, and increasing social competence.
- *Selective prevention* is targeted to individuals or subgroups whose risk of developing a disorder is above average. Examples include social cognitive skill building with children in families with mothers who are depressed or with children of parents undergoing separation or divorce.
- *Indicated prevention* is targeted to high-risk individuals who, on examination, manifest a risk factor, condition, or abnormality that identifies them, individually, as being at high risk for the future development of the disease. Examples include psychosocial and/or pharmacological interventions with persons in the initial phase of a disorder.
- *Prevention-minded treatment* is targeted to individuals who are at risk of more severe progressions of the mental illness, relapse, or co-morbidity. Examples include early identification of symptoms in a primary care setting, use of interdisciplinary (including pharmacological and behavioral) approaches in relapse prevention, prevention of substance abuse as a complication of social phobia, substance abuse as a complication of a childhood mental health disorder, and preventing the evolution of borderline and dissociative disorders in children currently in treatment for trauma and depression.

### Developmental Services

#### **Early Intervention Program**

Bureau of Child and Adolescent Health

New York State Department of Health

Corning Tower, Room 208

Albany, NY 12237-0618

518-473-7016

518-486-1090 fax

“Growing Up Healthy” 24-Hour Hotline

1-800-522-5006

1-800-577-2229 (New York City)

For information on developmental screening instruments for specific conditions, go to the New York State Department of Health’s website: [www.health.state.ny.us](http://www.health.state.ny.us). Click on the A-Z index, then on “Early Intervention Program.” Select Memoranda, Guidance, and Clinical Practice Guidelines.

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### AAP Policy

<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405>

The American Academy of Pediatrics (AAP) updated their guidelines for developmental surveillance in July 2006. Use the above link to access the policy statement: *Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening*.

## Substance Abuse Services

### Child Welfare Information Gateway

[http://www.childwelfare.gov/systemwide/service\\_array/substance/](http://www.childwelfare.gov/systemwide/service_array/substance/)

Formerly the National Clearinghouse on Child Abuse and Neglect, The Child Welfare Information Gateway has reorganized and substantially updated the Substance Abuse section of its website. Designed for child welfare, substance abuse, and other related professionals working with children, youth, and families affected by substance abuse, the section provides an [overview of the impact of substance abuse on child welfare](#), [resources for families](#), and information on [prevention](#), [assessment](#), [casework practice](#), [treatment services](#), [cross-system collaboration](#), and [drugs of particular concern](#).

### New York State Office of Alcoholism and Substance Abuse Services (OASAS)

For referrals to licensed treatment programs and substance abuse prevention services, contact OASAS at 1-800-522-5353 or go to [www.oasas.state.ny.us](http://www.oasas.state.ny.us). To request a listing of programs and services, contact OASAS publications at 518-457-9208. A national searchable treatment provider locator is also available on-line and may be accessed by going to <http://DASIS3.SAMHSA.gov/>

### Methamphetamine

The OASAS Methamphetamine Clearinghouse at <http://www.oasas.state.ny.us/meth/index.cfm> provides links to resources and information. For children exposed to meth, the Colorado Alliance for Drug Endangered Children site (<http://www.colodec.org/index.asp>) provides guidance. Select DEC Papers from the left side of the webpage to access the documents *National Protocol for Medical Evaluation of Children Found in Methamphetamine Labs* and *Medical Evaluation of Children Removed from Clandestine Labs FAQ #2*.

**Note:** These documents have not been endorsed by the NYS Department of Health or Office of Children and Family Services. They are referenced here for informational purposes.

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### Treatment of Adolescents With Substance Use Disorders

#### *Treatment Improvement Protocol (TIP) Series 32*

(available from <http://ncadi.samhsa.gov/>)

Excerpts from the Executive Summary and Recommendations:

This document, *Treatment of Adolescents With Substance Use Disorders*, is a revision and update of Treatment Improvement Protocol (TIP) 4, published in 1993 by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA). Like TIP 4, this document aims to help treatment providers design and deliver better services to adolescent clients with substance use disorders.

...Adolescent users differ from adults in many ways. Their drug and alcohol use often stems from different causes, and they have even more trouble projecting the consequences of their use into the future. In treatment, adolescents must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and environmental considerations (e.g., strong peer influences). At a physical level, adolescents tend to have smaller body sizes and lower tolerances, putting them at greater risk for alcohol-related problems even at lower levels of consumption. The use of substances may also compromise an adolescent's mental and emotional development from youth to adulthood because substance use interferes with how people approach and experience interactions.

The treatment process must address the nuances of each adolescent's experience, including cognitive, emotional, physical, social, and moral development. An understanding of these changes will help treatment providers grasp why an adolescent uses substances and how substance use may become an integral part of an adolescent's identity.

Regardless of which specific model is used in treating young people, there are several points to remember when providing substance use disorder treatment:

- In addition to age, treatment for adolescents must take into account gender, ethnicity, disability status, stage of readiness to change, and cultural background.
- Some delay in normal cognitive and social-emotional development is often associated with substance use during adolescence. Treatment for adolescents should identify such delays and their connections to academic performance, self-esteem, or social interactions.
- Programs should make every effort to involve the adolescent client's family because of its possible role in the origins of the problem and its ability to change the youth's environment.
- Although it may be necessary in certain geographic areas where availability of adolescent treatment programs is limited, using adult programs for treating youth is ill-advised. If this must occur, it should be done only with great caution and with alertness to inherent complications that may threaten effective treatment for these young people.

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- Many adolescents have explicitly or implicitly been coerced into attending treatment. Coercive pressure to seek treatment is not generally conducive to the behavior change process. Treatment providers should be sensitive to motivational barriers to change at the outset of intervention. Several strategies can be used for engaging reluctant clients to consider behavioral change.

...Treatment interventions fall along a continuum that ranges from minimal outpatient contacts to long-term residential treatment. All levels of care should be considered in making an appropriate referral. Any response to an adolescent who is using substances should be consistent with the severity of involvement. While no explicit guidelines exist, the most intensive treatment services should be devoted to youth who show signs of dependency – that is, a history of regular and chronic use – with the presence of multiple personal and social consequences and evidence of an inability to control or stop using substances.

### Informational Brochures

Publications available from the New York State Office of Alcoholism and Substance Abuse Services (OASAS) at <http://www.oasas.state.ny.us/pio/catalog.cfm> include:

- BR71 [Not Just a Game of Chance - Problem Gambling and Adolescents](#)
- BR16 Questions and Answers about Alcohol and Drugs
- PKT3 Tips for Teens packet (alcohol, crack/cocaine, hallucinogens, inhalants, marijuana)
- BR81 Tobacco Independence: Freedom from a Deadly Addiction
- BR26 FYI: Common Drugs and Symptoms of Abuse

*Keeping Your Teens Drug-Free: A Family Guide* (National Youth Anti-Drug Media Campaign). There are also guides for African-American Parents and Caregivers and Hispanic Families (bilingual). For copies, call 1-800-788-2800 or go to <http://www.theantidrug.com>.

### Growth and Development Charts

Health practitioners complete growth charts at regular check-ups and well child visits. Copies of these charts for boys and girls ages 0 to 36 months and 2 to 20 years can be found in the following pages and at [http://www.kidshealth.org/parent/growth/growth/growth\\_charts.html](http://www.kidshealth.org/parent/growth/growth/growth_charts.html). A Child Development Chart for the first five years is also included. These charts can be helpful to caseworkers and caregivers as they observe the child's growth and achievement of developmental milestones.

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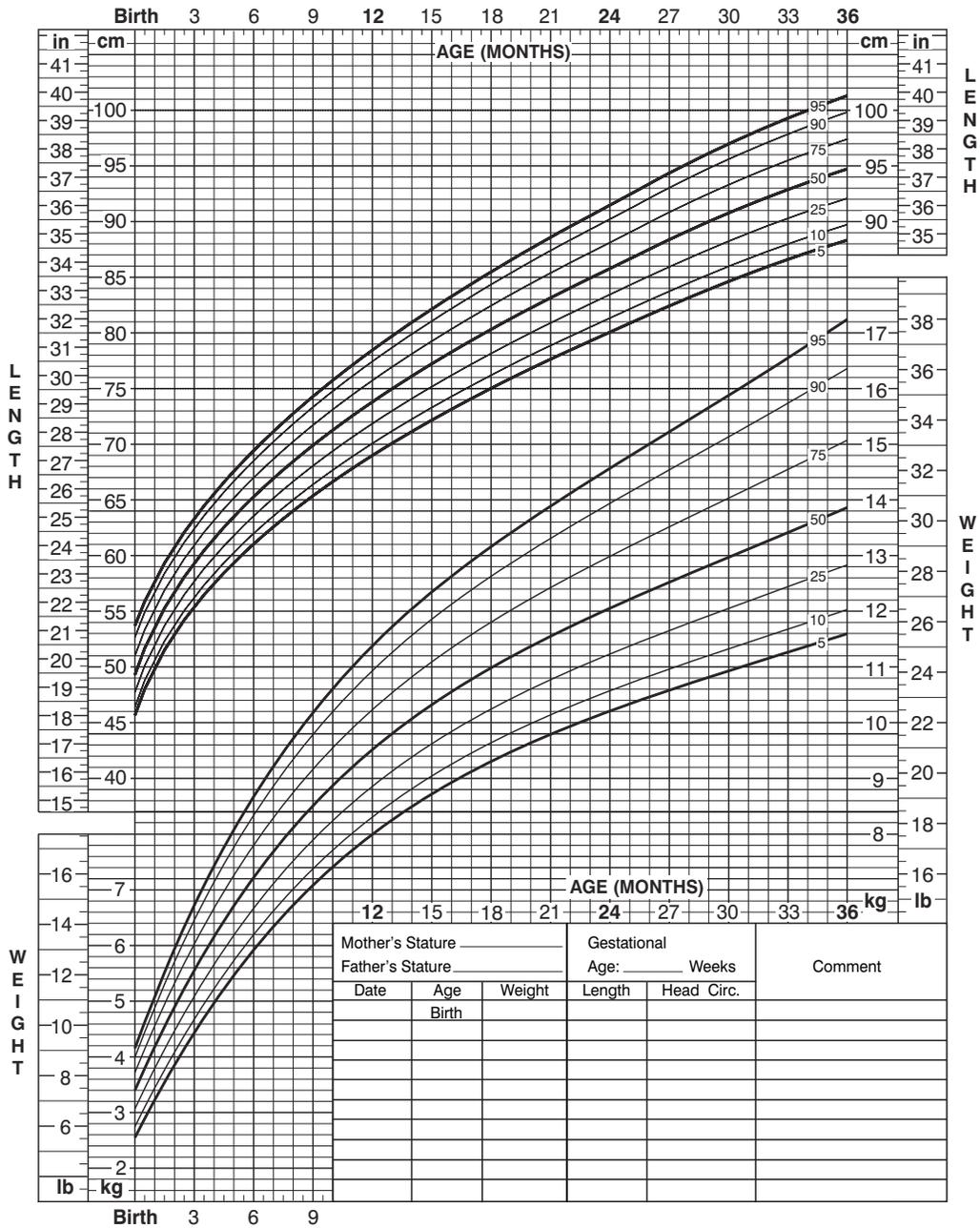
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Birth to 36 months: Girls

NAME \_\_\_\_\_

Length-for-age and Weight-for-age percentiles

RECORD # \_\_\_\_\_



Published May 30, 2000 (modified 4/20/01).  
 SOURCE: Developed by the National Center for Health Statistics in collaboration with  
 the National Center for Chronic Disease Prevention and Health Promotion (2000).  
<http://www.cdc.gov/growthcharts>



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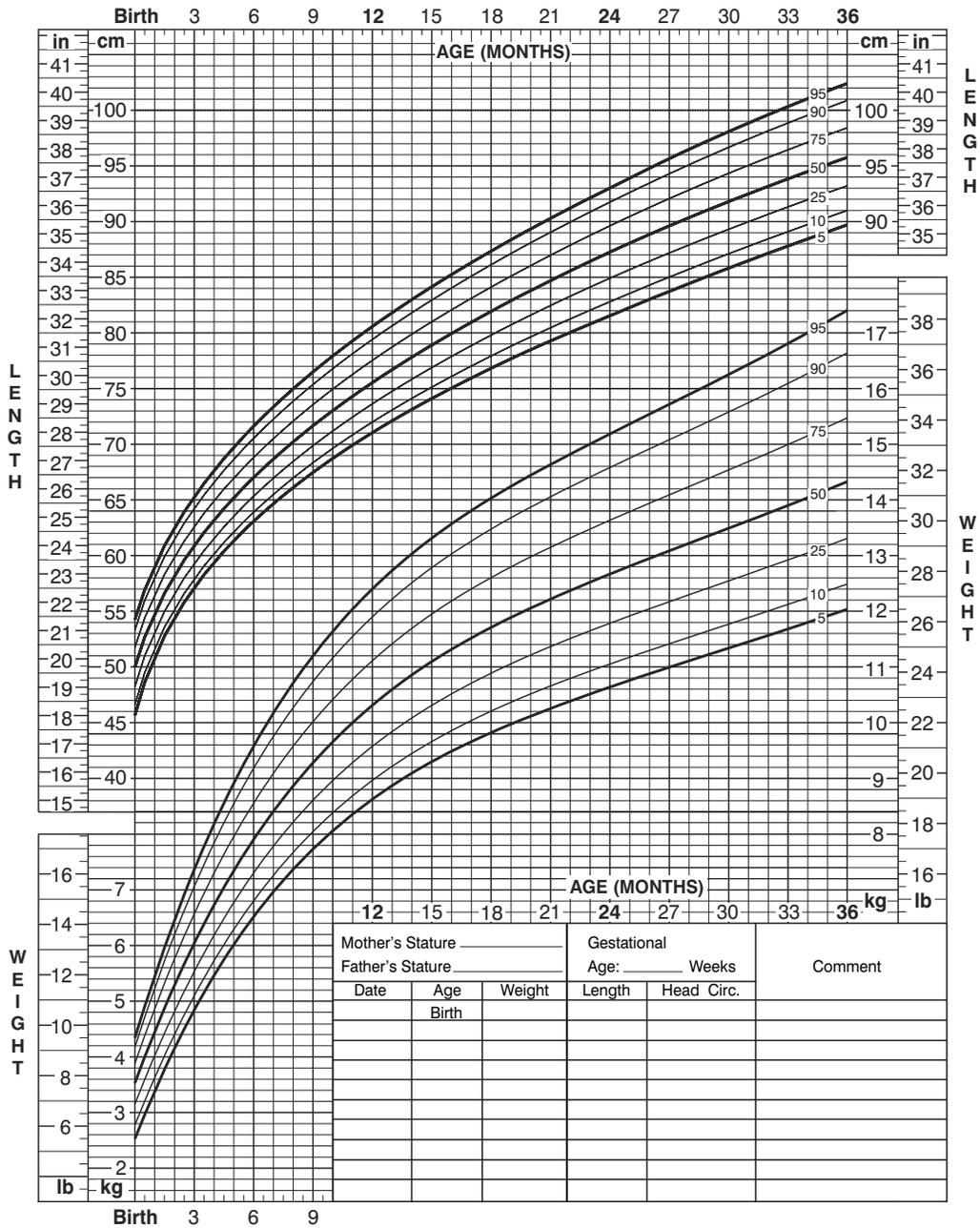
NYS Office of Children and Family Services

Birth to 36 months: Boys

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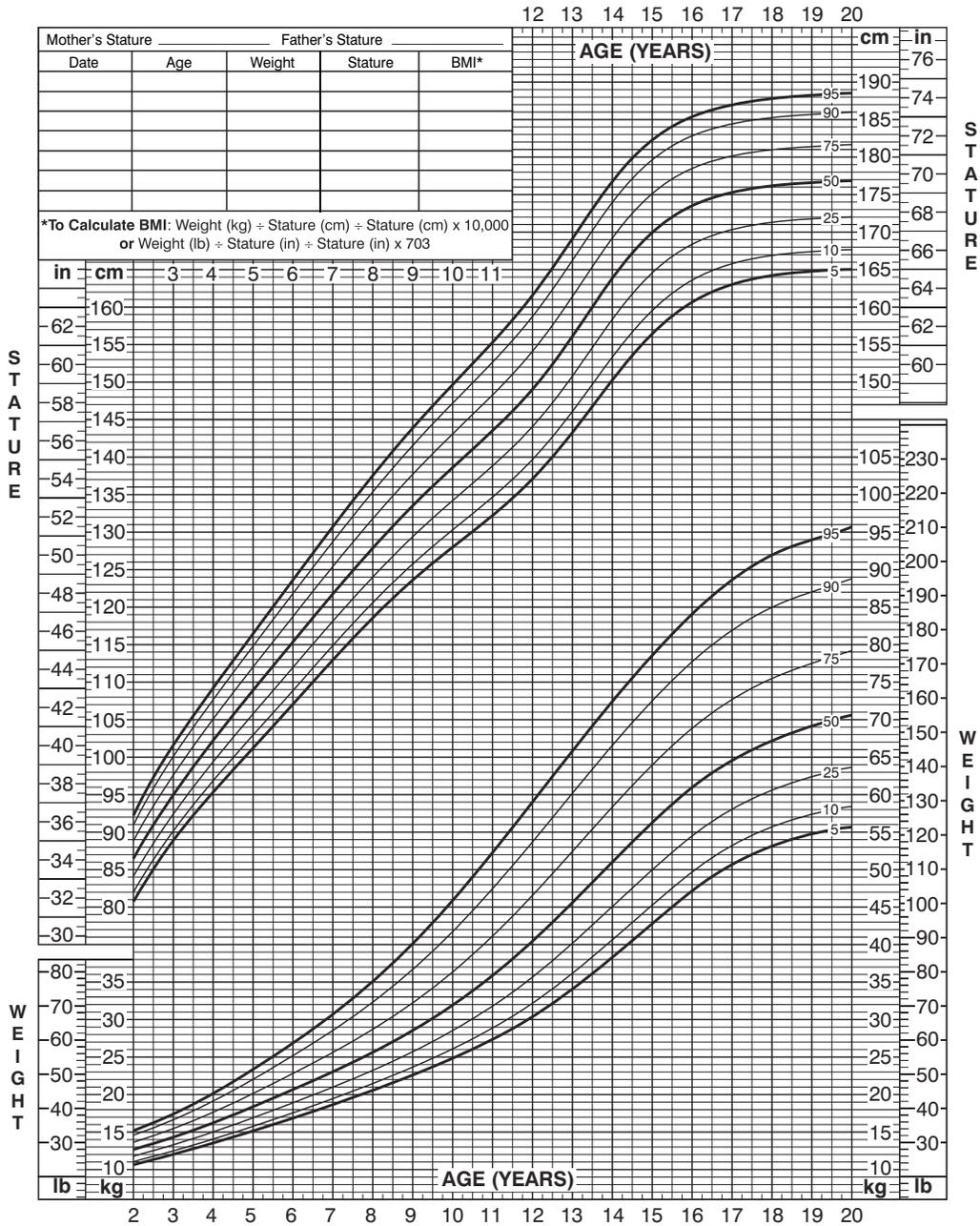
NYS Office of Children and Family Services

2 to 20 years: Boys

NAME \_\_\_\_\_

Stature-for-age and Weight-for-age percentiles

RECORD # \_\_\_\_\_



Published May 30, 2000 (modified 11/21/00).  
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).  
<http://www.cdc.gov/growthcharts>







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### Child Development Chart – First Five Years

SOCIAL	SELF-HELP	GROSS MOTOR	FINE MOTOR	LANGUAGE
<b>Birth to 6 Months</b>				
Social smile Distinguishes mother from others	Reacts to sight of bottle or breast Comforts self with thumb or pacifier	Lifts head and chest when lying on stomach Turns around when lying on stomach	Looks at and reaches for faces and toys Picks up toy with one hand	Reacts to voices – vocalizes coos, chuckles Vocalizes spontaneously – social
<b>6 to 9 Months</b>				
Reaches for familiar persons Pushes things away he/she doesn't like	Feeds self cracker	Rolls over from back to stomach Sits alone...steady without support	Transfers toy from one hand to the other Picks up object with thumb and finger grasp	Responds to name – turns and looks Wide range of vocalizations (vowel sounds, consonant-vowel combination)
<b>9 to 12 Months</b>				
Plays social games, peek-a-boo, bye-bye Plays patty-cake	Picks up a spoon by the handle	Crawls around on hands and knees Walks around furniture or crib while holding on	Picks up small objects – precise thumb and finger grasp	Word sounds – says "Ma-ma" or "Da-da" Understands words like "No" "Stop" or "All gone"
<b>12 to 18 Months</b>				
Wants stuffed animal, doll or blanket in bed Gives kisses or hugs G greets people with "hi" or similar	Lifts cup to mouth and drinks Feeds self with spoon Insists on doing things by self such as feeding	Stands without support Walks without help Runs	Stacks two or more blocks Picks up two small toys in one hand Scribbles with crayon	Uses one or two words as name of things or actions Talks in single words Asks for food or drink with words
<b>18 Months to 2 Years</b>				
Sometimes says "No" when interfered with Show sympathy to other children – tries to comfort them Usually responds to correction – stops	Eats with fork Eats with spoon, spilling little Takes off open coat or shirt without help	Kicks a ball forward Runs well, seldom falls Walks up and down stairs alone	Builds towers of four or more blocks Turns pages of picture books, one at a time	Follows simple instructions Uses at least ten words Follows two-part instructions
<b>2 to 3 Years</b>				
"Helps" with simple household tasks Plays with other children – cars, dolls, building Plays a role in "pretend" games – mom-dad, teacher, space pilot	Opens door by turning knob Washes and dries hands Dresses self with help	Climbs on play equipment – ladders, slides Stands on one foot without support Walks up and down stairs – one foot per step	Scribbles with circular motion Draws or copies vertical lines Cuts with small scissors	Talks in two-three word phrases or sentences Talks clearly, is understandable most of the time Understands four prepositions – in, on, under, beside
<b>3 to 4 Years</b>				
Gives direction to other children Plays cooperatively, with minimum conflict and supervision Protective toward younger children	Toilet trained Washes face without help Dresses and undresses without help except for shoelaces	Rides around on a tricycle, using pedals Hops on one foot without support	Draws or copies a complete circle Cuts across paper with small scissors	Combines sentences with the words "and" "or," or "but" Identifies four colors correctly Counts five or more objects when asked "How many?" Understands concepts – size, number, shape
<b>4 to 5 Years</b>				
Follows simple rules in board or card games Shows leadership among children	Buttons one or more buttons Usually looks both ways before crossing street Goes to the toilet without help	Skips or makes running "broad jumps" Swings on swing, pumping by self	Draws recognizable pictures Draws a person that has at least three parts – head, eyes, nose, etc. Prints first name (four letters)	Follows a series of three simple instructions Reads a few letters (five +) Tells meaning of familiar words

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### ***Chapter Three***

## Special Health Care Services

To address the significant health issues of children in foster care, agencies are responsible for providing comprehensive health services, documenting such services, and maintaining current records.<sup>1</sup> This chapter describes services ranging from the Bridges to Health Waiver Program to HIV-related services.



Sections in this chapter include:

1. Bridges to Health
2. HIV-related services
3. Family planning, sexuality education, and reproductive health services
4. Services for gay, lesbian, bisexual, transgender, and questioning youth
5. Special services for school-age youth
6. Resources

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<sup>1</sup> 18 NYCRR 441.22(a); 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

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### 1 Bridges to Health

Bridges to Health (B2H) is a home and community-based Medicaid waiver program for children in foster care. B2H is one state program that consists of three Home and Community Based Medicaid Waivers serving children in three disability groups:

- B2H for children with Serious Emotional Disturbances (SED)
- B2H for children with Developmental Disability (DD)
- B2H for children with Medical Fragility (MedF)

Once in the B2H program, children may be eligible for B2H services after discharge from foster care until age 21 if the child remains otherwise eligible.

A Medicaid waiver offers services not otherwise available in the community that will be provided and paid for through Medicaid. B2H is specifically tailored to address unmet health and other needs related to a child's serious emotional disturbances, developmental disabilities, and/or physical health issues. B2H services supplement and complement, but do not replace, existing Medicaid and child welfare services.

This program provides services to children with complex medical conditions in the context of their family and caregiver network. By supporting children in foster care in the least restrictive home or community setting, the B2H Waiver Program provides opportunities for improving the health and well-being of the children served, and supporting permanency planning. B2H is a voluntary program and cannot be mandated. Freedom of choice of services and service providers is fundamental.

Participation in the program may:

- allow the child to step down a level of care (e.g., move from a psychiatric hospital to a foster home);
- avert a higher level of placement for the child (e.g., from a foster home to a medical institution);
- avert the placement of a child out of state; or
- allow the child to move out of foster care sooner.

### Waiver Services

The B2H Waiver Program services are available to all waiver enrollees, regardless of the qualifying diagnosis. This means that B2H is able to assist children with cross-system needs.

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The 14 services are as follows:

- Health Care Integration
- Family/Caregiver Supports and Services
- Skill Building
- Day Habilitation
- Special Needs Community Advocacy and Support
- Prevocational Services
- Supported Employment
- Planned Respite
- Crisis Avoidance, Management, and Training
- Immediate Crisis Response Services
- Intensive In-home Supports
- Crisis Respite
- Adaptive and Assistive Equipment
- Accessibility Modifications

### Eligibility and Enrollment in B2H Waiver Program

Eligibility criteria, including qualifying diagnoses, are listed in the B2H Program Manual, accessible on the B2H website: <http://www.ocfs.state.ny.us/main/b2h/>. A child must be Medicaid eligible (all children in foster care who are citizens or have satisfactory immigration status are categorically eligible for Medicaid).<sup>2</sup> The child must also be in foster care or in OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY) community services supervision to enter B2H. Once enrolled, the child may continue to receive B2H waiver services until age 21 if he or she continues to meet eligibility requirements, even after discharge from foster care.

The formal referral of children to B2H must come from the local department of social services (LDSS) or DJJOY. The LDSS/DJJOY first determines if the child is a candidate for the program and the availability of waiver slots. Then the LDSS/DJJOY prepares an application which includes documentation of a qualifying diagnosis, and submits it to a Health Care Integration Agency (HCIA) selected by the child or medical consentor. From that point on, the LDSS/DJJOY and HCIA will work closely with the child and medical consentor to enroll the child, if appropriate, and coordinate services.

### Coordinating B2H and Foster Care Services

A Health Care Integrator (HCI) from the HCIA will work directly with each child enrolled in B2H to oversee waiver services. Routine health care outside of waiver services continues to be the responsibility of the foster care case manager. It is important for the HCI and case manager to form a complementary relationship and share information in support of the child's permanency, health, and well-being.

The HCI will develop an Individualized Health Plan for B2H waiver services that is subject to approval by the LDSS/DJJOY. This plan should be considered a component of the Family Assessment and Service Plan (FASP). To promote a free flow of information, the HCI enters progress notes into CONNECTIONS and should be included as a participant in team meetings and service plan reviews.

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<sup>2</sup> GIS 05 MA/041.

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## 2 HIV-Related Services

Required HIV-related services for children in foster care include:

- HIV risk assessment.
- Assessment of capacity to consent to an HIV test.
- Counseling and HIV antibody testing for children at risk.
- Referral of HIV-infected children for appropriate medical and psychological services.<sup>3</sup>

*(See Chapter 1, Initial Evaluation of Child's Health, for information on HIV risk assessment when children enter foster care; see Chapter 6, Medical Consents, for a discussion of the consent issues related to HIV risk assessment and services; see Chapter 7, Confidentiality of Health Information, for a discussion of confidentiality and HIV.)*

The AIDS Institute of the New York State Department of Health (DOH) recommends that agencies provide the following special services related to the special needs of HIV-infected children. If your agency does not provide these services, make sure that you know where you can refer children to obtain them.

### Prevention Education

Whether provided by the health practitioner, agency health staff, or caseworkers, information on the risks and prevention of HIV is essential for children and youth in foster care. As appropriate for age and risk, such anticipatory guidance can be part of a broader health education program that includes discussion on sexuality, family planning, and sexually transmitted disease (STD) prevention. Be prepared and trained with current information if it is your role to interview and counsel children in foster care about these matters.

Agency staff should become comfortable with discussing sexual topics in general and in relation to HIV/AIDS. The next step is to help foster parents also become comfortable in discussing these issues with the children and youth in their care. Training and ongoing discussion with foster parents can assist in furthering their ability. Contact the staff development coordinator in your local district for information.

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<sup>3</sup> 18 NYCRR 441.22(b); 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure.

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### HIV Counseling and Testing

Counseling and testing services should be readily available to all children and youth. These services may be offered by a counselor certified by a DOH-sponsored counselor training course or by an organization such as a community health care agency.

Remember that counseling about HIV may be used as an opportunity to provide individual prevention education, including advice on changing behavior.

When a foster child has the capacity to consent, and HIV risk has been identified, the child or youth has the right to make all decisions about an HIV test, the type of test, and a *limited right* to make certain decisions about disclosure of information related to an HIV test. Part of the counseling of children with capacity to consent is informing them about these rights (*see Chapter 7, Confidentiality of Health Information*).

After being counseled about testing, the child or youth has the right to decide whether to have agency-supervised confidential HIV-related testing or the alternative of anonymous testing. If the choice is confidential testing, the test results will be included in the child's confidential health record. When anonymous testing is chosen, only the child or youth will receive the test result, and no information linking the youth's identity to the test request or result will be gathered or kept.

Points to remember about HIV testing include:

- HIV testing is done only with appropriate consent (*see Chapter 6, Medical Consents*).
- Results of HIV testing will be in the confidential health record unless the child has chosen anonymous testing.
- Results of HIV testing will be made available only to persons authorized to receive such information under law and regulation, or by consent.<sup>4</sup>

For more information on HIV counseling and testing, contact:

- New York State Department of Health: HIV/AIDS Counseling/Testing Hotline (800-962-5065); or go to [www.health.state.ny.us](http://www.health.state.ny.us), and click on HIV/AIDS (or <http://www.health.state.ny.us/diseases/aids/testing/>).
- Your county health department.
- In New York City, the Pediatric AIDS Unit (PAU) (212-341-8943) of the New York City Administration for Children's Services (ACS).

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<sup>4</sup> 18 NYCRR 441.22(b); 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure.

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### Placement of HIV-Infected Children

Children with HIV may require specialized services and extra efforts to meet their often complicated and enhanced needs. Whenever possible, HIV-infected children should be placed with an agency that has staff and foster parents who are knowledgeable about issues related to HIV. Certain agencies receive enhanced rates to provide specialized services.

When children with HIV are not placed in a special program, the agency needs to provide the necessary supportive nursing and psychosocial services and training to the child and foster family. For example, a child may be placed in a foster home with a sibling and is discovered later to have HIV. In the interest of keeping the siblings together, HIV-related training should be provided to the foster parents.



#### Health Care Coordination Activities

Make sure that medical follow-up is taking place, the caregiver is adhering to the child's medication schedule, and the child's counseling needs are being met.

Remember that many children with HIV have also suffered family losses. These issues of loss and grief need to be addressed. Adolescents need to assess the impact of HIV on their sexual development and exploration.

### Medical Care for HIV-Infected Children

Children in foster care who are HIV-infected should receive medical care from specialized pediatric or adolescent HIV/AIDS providers that have 24-hour coverage, seven days a week, including after-hours coverage. Providers should offer a comprehensive package of health care and support services to meet the multiple needs of children with HIV and their families. Whenever possible, care should be continued with the HIV specialist (who may be the primary care provider) who provided care to the child prior to foster care placement.

Foster parents who are caring for children with HIV will find helpful information in the NYS DOH/OCFS manual, *Caring for Children with Special Needs: For Parents, Foster Parents, and Other Caregivers Caring for Children with HIV*, September 2003. To obtain a copy of the manual, contact the NYS Department of Health at 518-474-9866. It can also be downloaded from <http://www.health.state.ny.us/diseases/aids/resources/child/index.htm>.

It is crucial that foster care agencies, foster parents, and congregate care facilities strictly adhere to the medication schedules that are prescribed for each child with HIV. Your agency should have methods for monitoring and assuring that medication schedules are followed precisely as written by the prescribing practitioner (*see Chapter 5, Medication Administration and Management*). If adherence to the medication schedule is problematic, the prescribing practitioner should be consulted.

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An enhanced chronic care schedule for clinical monitoring of HIV-positive infants and children is recommended by the AIDS Institute (<http://www.hivguidelines.org/>):

- Monthly for the first year of life.
- Every three months thereafter.

### Clinical Trials for HIV-Infected Children

A clinical trial is a research study in human volunteers to answer specific health questions. Carefully conducted clinical trials are the fastest and safest way to find treatments that work in people and ways to improve health (see <http://www.clinicaltrials.gov/>, a site of the National Institutes of Health). Access to clinical trials for children with HIV infection can be provided following the procedures established by the local social services district and approved by NYS OCFS, Division of Strategic Planning and Policy Development (SPPD).

### Newborn Screening Program

Under New York State law, a sample of blood is taken from every newborn to test for over 40 disorders. Since February 1, 1997, the Newborn Screening Program has included an HIV antibody test. Although most of the screened disorders are rare, they are usually serious. Some may be life threatening; others may slow down a baby's physical development or cause mental retardation or other problems if left untreated. None of the disorders can be cured. However, serious side effects can be lessened, and often completely prevented, if a special diet or other medical intervention is started early.

Blood is usually taken for the Newborn Screening on the day that the infant is discharged from the hospital. The screening results are provided to the pediatrician. Request this information from the pediatrician and include the screening results in the medical record maintained by the foster care agency for each child in care. If you have difficulty accessing the screening information, assistance is available. The OCFS Office of Regional Operations and Program Improvement (ROPI) is responsible for coordinating Newborn Screening requests by local departments of social services (not including New York City) to the NYS DOH for children in foster care. Call ROPI at 518-474-8629 (currently Michael Monahan) for counties outside of New York City; in NYC, call the ACS Pediatric AIDS Unit (PAU) at 212-341-8943.

Results of the entire Newborn Screening panel should be reviewed by the child's medical home. Follow-up may be needed to rule in or rule out a condition or monitor a disease process. If the screening is positive for HIV antibodies, this means that the mother was HIV positive and the child has been exposed to the virus. HIV-exposed newborns need repeat testing to see if they are infected. Testing and treatment protocols are included in the Clinical Guidelines, found at <http://www.hivguidelines.org/>.

Information about the Newborn Screening Program is available at <http://www.wadsworth.org/newborn/>.

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Risk Assessment <sup>5</sup>	
<p>The skillful gathering of information related to the risk of HIV infection should become standard practice in compiling histories of children, youth, and their families. Knowledge of the risk of HIV infection must become part of everyday awareness, as has knowledge of alcoholism or drug abuse, and be incorporated into routine history-taking.</p> <p>The best starting point in determining the risk level for a particular infant, child, or youth is a careful assessment of the birth parents.</p>	
<p><b>Medical and psychosocial history of parent or sexual partner of parent</b> <i>(perinatal transmission)</i></p>	<p>The parent or parent's sexual partner has:</p> <ul style="list-style-type: none"> <li>■ diagnosis of HIV infection, symptoms of HIV, or died due to HIV.</li> <li>■ had male sexual partner who was a male who sleeps with males (MSM).</li> <li>■ history of STDs.*</li> <li>■ had multiple sex partners or exchanged sex for money, food, housing, etc. prior to child's birth.</li> <li>■ history of tuberculosis.</li> <li>■ injected illegal drugs, shared needles, or other equipment involved with drug use or piercing.</li> <li>■ used non-injection illegal drugs.</li> <li>■ had a blood/blood products transfusion between January 1978 and July 1985 in U.S.</li> <li>■ had blood transfusion in other country at time when blood was not screened for HIV.</li> </ul>
<p><b>Risk factors for infants &amp; preschool children</b> <i>(perinatal transmission: pregnancy, birth, breast-feeding)</i></p>	<p>The child:</p> <ul style="list-style-type: none"> <li>■ has positive drug toxicology/drug withdrawal at birth.</li> <li>■ tests positive for syphilis at birth.</li> <li>■ has symptoms consistent with HIV infection.</li> <li>■ has/had sibling with HIV, or initially tested positive but seroreverted to negative.</li> <li>■ was abandoned at birth with no risk history available.</li> </ul> <p>Assessment should continue with examination of the child's behavior. This information should be gathered carefully, with respect for privacy and confidentiality.</p>
<p><b>Child's behavior</b> <i>(direct transmission)</i></p>	<p>The child has:</p> <ul style="list-style-type: none"> <li>■ symptoms of HIV infection.</li> <li>■ been sexually abused.</li> <li>■ engaged in sexual activity.</li> <li>■ history of STDs.*</li> <li>■ had multiple sex partners or exchanged sex for money, food, housing, etc.</li> <li>■ history of tuberculosis.</li> <li>■ injected illegal drugs, shared needles, or other equipment involved with drug use or piercing.</li> <li>■ used non-injection illegal drugs.</li> <li>■ had a blood/blood products transfusion between January 1978 and July 1985 in U.S.</li> <li>■ had blood transfusion in other country at time when blood was not screened for HIV.</li> </ul>
<p>The above risk factors are listed in 97 ADM-15.</p>	
<p>As a result of recent research on HIV, additional risk factors have been identified by the NYS DOH AIDS Institute:</p>	<p>The child has:</p> <ul style="list-style-type: none"> <li>■ tattoos</li> <li>■ hepatitis C</li> </ul>

\*Sexually Transmitted Disease such as syphilis, gonorrhea, hepatitis B, or genital herpes.

<sup>5</sup> 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure.

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### 3 Family Planning, Sexuality Education, and Reproductive Health Services

Youth in foster care age 12 and older, and younger children who are known to be sexually active, need age-appropriate education and counseling on sexuality, pregnancy prevention, family planning, and sexually transmitted diseases. These services may be provided directly by your agency or by agreements with health-related community organizations. In any case, such services must be readily available and provided by professionals trained and experienced in family planning education, gynecological care, and contraception for adolescents. The discussion of these subjects, along with the family planning notice (*see below*), should begin at the first conference with the foster parents and the youth, if appropriate.

➔ See section 6, Resources, for a list of resources and websites related to reproductive and sexual health. Also provided is a list of health websites specifically for teens.

#### Notice of Family Planning Services

When a youth age 12 or older is placed in foster care, his or her foster parent must be informed in writing within 30 days of placement, and annually thereafter, of the availability of social, educational, and medical family planning services for the youth.<sup>6</sup> This notice, or offer, may be made orally as long as it is also made in writing (*see Appendix A for a sample Family Planning Notice*). Place a copy of the family planning notice and the date it was made in the youth's medical and case records.

If the local district's policy is to make an offer directly to all adolescents within the district, the notice of family planning services also must be made directly to the youth in foster care.<sup>7</sup> As with the notice to foster parents, you may discuss the availability of services orally, but you must also provide written notice and file a copy of the notice in the youth's record. Minors can consent to their own treatment regarding STD testing and counseling, contraceptive services, and pregnancy, including abortion (*see Chapter 6, Medical Consents*).

<sup>6</sup> 18 NYCRR 441.22(1)(1) and 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

<sup>7</sup> 18 NYCRR 441.22(1)(2) and 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

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### Family Planning Services

State and federal mandates require that family planning services be provided to youth in foster care age 12 and older, upon request.<sup>8</sup> Referrals should be made within 30 days of the request to services provided directly by your LDSS, through contract agencies, or by community health care providers. For information on family planning programs in your community, contact the NYS Department of Health at 518-474-3368.



#### Health Care Coordination Activities

Develop a list of family planning providers in your community. Share this list of resources with youth and caregivers. Be sure to update the list regularly.

### Community Prevention Programs

The Adolescent Pregnancy and Prevention Services (APPS) program assists high need communities to develop a comprehensive array of services to prevent unwanted pregnancies for at-risk youth through 21 years of age. This is accomplished through coordination of existing services in the community and creation of new services to meet needs identified by a community needs assessment. The Teenage Services Act (TASA) provides case management for teens who are pregnant or parenting and receiving temporary assistance. The program focuses on pregnant adolescents to assist them in accessing prenatal care and services to avoid complications such as low birth weight and fetal deaths. TASA is provided or arranged for by the LDSS in each county.

### Routine Gynecological Care

As part of routine health care, all female adolescents age 12 and older or at the onset of puberty should be referred for a gynecological examination, as appropriate. Examples include adolescents who are thinking about becoming sexually active or who are already sexually active, or when there are medical concerns such as menstrual problems.

### Pregnancy

When an adolescent is pregnant, or pregnancy is suspected, the first step is to obtain prompt medical care and counseling. Emergency contraception should be offered to any young woman who does not wish to become pregnant and has had unprotected sexual intercourse within the preceding three days.

If pregnancy is confirmed, the adolescent needs care and support in exploring and deciding upon a possible course of action. Topics to cover in counseling an adolescent who is pregnant include:

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<sup>8</sup> 18 NYCRR 507.1(c)(9).

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- Identifying her concerns, fears, and wishes.
- Discussing whether she wants to involve her birth parents and/or the baby's father in planning.
- Determining whether she will be able to remain in her current foster care placement.
- An objective review and discussion of the alternatives and their implications, including adoption of the baby, pregnancy termination, living arrangements if she keeps the baby, and school attendance (education).
- Helping her implement her decisions.

Prenatal/postpartum care should be consistent with current professional standards of care. American College of Obstetricians and Gynecologists (ACOG) Standards for reproductive health and the birth process should be employed.

The privacy (confidentiality) of an adolescent who objects to her parent/guardian being informed of the possibility of pregnancy is protected under New York State Law. However, continuing efforts should be made (and documented) to encourage her to involve her parent/guardian, if appropriate, and caregivers as early as possible as these individuals can provide valuable support and resources.



### Health Care Coordination Activities

Pregnant adolescents may be able to continue attending school and participating in activities up to a point recommended by their doctor. Monitor the ongoing medical care during and following pregnancy, verifying that she keeps her appointments and that the foster parents are informed and involved in the situation. Keep in mind that teens in foster care may consent for their health care during pregnancy. It is not necessary to obtain consent from the parent or guardian for services related to prenatal care (*see Chapter 6, Medical Consents*).

Good sources of support available through the New York State Department of Health are the Growing Up Healthy Hotline, the Prenatal Care Assistance Program (PCAP), the Medicaid Obstetrical and Maternal Services (MOMS) Program, the Comprehensive Prenatal Perinatal Services Network, and the Community Health Worker Program (CHWP) (*see section 4, Resources*).

## Sexually Transmitted Diseases

Children and adolescents who engage in unprotected sexual activity have high rates of sexually transmitted diseases and are at risk of HIV infection. As part of the family planning discussion, provide age-appropriate instruction regarding abstinence, safer sex, prevention of STDs, diagnosis and treatment, and the risk of repeated infections.

A new study from the Centers for Disease Control (CDC) indicates that approximately one in four (26%) female adolescents (age 14-19) in the United States has at least one of the most common sexually transmitted infections (STIs). The infections included were human papillomavirus (HPV)

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infection, chlamydia, herpes simplex virus type 2 (HSV-2) infection, and trichomoniasis. African-American teenage girls had the highest prevalence, with an overall STI prevalence of 48 percent compared to 20 percent among both whites and Mexican Americans.<sup>9</sup>

STDs, particularly for females, may have no obvious symptoms. Urine screening is useful to identify asymptomatic chlamydia and gonorrhea. STD testing should be a routine part of primary care for sexually active adolescents. Testing should also be considered when a child returns from an absence without consent if there are concerns that sexual activity occurred.

Current STD treatment guidelines are available from the CDC at <http://www.cdc.gov/std/treatment/2006/toc.htm>.

### Human Papillomavirus (HPV)

It is estimated that 20 million people in the U.S. are currently infected with HPV.<sup>10</sup> Different strains of this virus cause genital warts and cervical cancer. Though it is important to note that most HPV infections clear on their own, some may persist, putting the young woman's health at risk.

A vaccine to protect against HPV is available and should be administered as a routine immunization. (*see Recommended Childhood Immunization Schedule, page 1-25*). To be most effective, the vaccine should be given before the girl is sexually active. However, it is appropriate for all women and girls ages 8 to 26, regardless of whether they are sexually active or already infected with HPV. Females entering and already in foster care should receive the HPV series of vaccinations if they have not yet been administered. The parent/guardian's signed consent for routine medical treatment is sufficient; no additional consent is required.

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<sup>9</sup> 2008 National STD Prevention Conference. *Oral Abstract—Prevalence of Sexually Transmitted Infections and Bacterial Vaginosis among Female Adolescents in the United States: Data from the National Health and Nutrition Examination Survey (NHANES) 2003-2004.*

<http://www.cdc.gov/stdconference/2008/media/summaries-11march2008.htm#tues1>

<sup>10</sup> NYS Department of Health. *Questions and Answers about Human Papillomavirus (HPV) Vaccine* ([http://www.nyhealth.gov/diseases/communicable/human\\_papillomavirus/fact\\_sheet.htm](http://www.nyhealth.gov/diseases/communicable/human_papillomavirus/fact_sheet.htm))

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### 4 Services for Gay, Lesbian, Bisexual, Transgender, and Questioning Youth

Be sensitive to the reality that some young people in foster care are gay, lesbian, bisexual, transgender, or questioning their sexual orientation or gender identity (GLBTQ). This means that the child may be sexually attracted to and/or sexually involved with people of the same gender. A transgender child identifies with a gender that is different from his/her birth-assigned gender (*see section 5, Resources, for definitions and terms*).

These youth face special challenges as they negotiate their sexual orientations in a society often hostile to nontraditional sexual identities. They may be targeted for bullying and violence because of others' inability to accept alternative lifestyles and sexual orientation. The risks of running away, suicide, and other acting out behaviors are high.

“Child welfare organizations that understand and address the needs of these youth will, over the long term, create safer, more open agencies and improve the quality of services they provide to all the children and youth in their care, regardless of their sexual orientation or gender preference.”<sup>11</sup> At a minimum, GLBTQ youth in foster care need:

- A safe, secure, accepting environment with tolerance for self-expression in areas such as dress and behavior.
- Health services to meet the special health needs of gay, lesbian, and transgender youth by professionals who are experienced in their care.

A recent survey of high school youth found that 5.5 percent self-identified as gay, lesbian, or bisexual and/or reported same-gender sexual contact.<sup>12</sup> Since this may not include transgender and questioning youth or those who are fearful of sharing this personal information, it is likely that the numbers are higher.

In addition to being aware about sexual orientation issues, keep the following risk factors in mind:<sup>13</sup>

- Violence in school
- Lack of role models
- Substance abuse
- STD/HIV infection
- Depression and suicide
- Cultural rejection

<sup>11</sup> Teresa DeCrescenzo and Gerald P. Mallon, *Serving Transgender Youth: The Role of Child Welfare Systems* (Washington, D.C.: Child Welfare League of America, 2000), p. v.

<sup>12</sup> Massachusetts Department of Education. *Massachusetts High School Students and Sexual Orientation: Results of the 1999 Youth Risk Behavior Survey* (Boston, MA: The Department, 1999).

<sup>13</sup> Advocates for Youth, [www.advocatesforyouth.org/publications/factsheet/fsglbt.htm](http://www.advocatesforyouth.org/publications/factsheet/fsglbt.htm).

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### Health Care

Tips for staff working with GLBTQ youth in foster care include:<sup>14</sup>

- Youth who engage in heterosexual sexual relations may not be exclusively heterosexual (this includes pregnant teenagers who may be lesbians but also engaged in heterosexual intercourse).
- Gynecological visits can often alienate lesbians because of prevailing heterosexual assumptions.
- Gay males may learn about being gay through sexual experiences, thereby increasing the risk of STD/HIV exposure.
- Gay males may be at risk for eating disorders (in contrast to young lesbians, with whom this does not seem to be an issue).
- Many transgender youth do not seek services in the health care system due to fear of ridicule, rejection, or harassment.
- Be aware of cultural issues related to sexual orientation and self-identification.

### Mental Health

Recognize the inherent psychological stress of being stigmatized and/or keeping secret one's sexual orientation. The chronic stress of fear for safety, others finding out, and coming out (realizing sexual orientation), when combined with the stress of moving into a foster home or residential setting increases anxiety and mental health problems. Multiple and unstable placements are not uncommon for adolescents, and especially for GLBTQ youth.

The term *transgender* refers to all those who challenge the socially-accepted definitions and boundaries of sex and gender. Puberty is a particularly difficult time for youth struggling with their gender identity since these youth rarely have support systems to make sense of their physical changes. These changes may shame or repulse transgender youth and lead to attempts to change their physical appearance by concealing and/or injuring unwanted body parts. Some transgender males engage in high-risk behaviors to purchase feminizing hormone drugs. The unsupervised use of hormones presents physical as well as mental health issues that should be addressed by the treatment team, with the adolescent's participation. Another risk for transgender youth is alcohol and substance use to cope with feelings of depression and anxiety.

Be aware that teens who feel alienated from the health care system may not follow through with recommended treatment. As a result, they may not receive health care on a consistent basis.

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<sup>14</sup> Gerald P. Mallon, *Lesbian and Gay Youth: A Practical Guide for Youth Workers* (Washington, D.C.: CWLA Press, 2001).

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**Note:** It is important to remember that GLBTQ youth may seek or require mental health services for reasons unrelated to their sexual orientation.



### Health Care Coordination Activities

To address the special needs of GLBTQ youth, consider the following three areas: organizational changes, in-service trainings, and welcoming strategies.

## Organizational Changes

Consider the following questions to determine whether your agency provides a positive, healthy environment for GLBTQ youth:

- Has your agency worked with GLBTQ youth in the past?
- How often has your agency's staff had training, and of what type, in working with GLBTQ youth?
- What is your agency's treatment philosophy for working with GLBTQ youth?
- Do agency policies specifically address the needs of GLBTQ youth?
- Do agency brochures and outreach materials include photos or references to GLBTQ youth?
- Does your agency have linkages with GLBTQ youth organizations?
- Is the issue of acceptance of GLBTQ children addressed in certification interviews with foster parents who may be caring for them?
- Are the health care providers you use familiar with the unique needs of GLBTQ youth?

## In-Service Trainings

To address the needs of GLBTQ youth, training for agency staff and caregivers should:<sup>15</sup>

- Identify appropriate language.
- Counteract common myths and stereotypes.
- Replace myths with accurate information.
- Teach how to create a safe environment.

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<sup>15</sup> DeCrescenzo and Mallon.

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- Assess personal biases and prejudices.
- Identify community resources.
- Show videos and have guest speakers [e.g., Parents and Friends of Lesbians and Gays (PFLAG) can often provide well-trained speakers for in-service training programs].
- Be offered on an ongoing basis.

### Welcoming Strategies

Create an open and respectful waiting room, including reading materials and signs or symbols that specifically spell out your agency's attitude about respect for all people. This can include "Hate-Free Zone" posters and subtle posters or signs (e.g., a rainbow) that indicate acceptance of all youth.

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### 5 Special Services for School-Age Youth

Additional important services address concerns, issues, and activities that have health and mental health implications for school-age youth.

#### Violence and Trauma

History of violence in the family, peer-induced violence, and exposure to violence are crucial parts of the history-taking portion of the comprehensive health assessment. Assessment of family violence is also an integral part of the child abuse and neglect evaluation and may yield information about other types of violence. For example, many youth are exposed to violence through peers, such as gangs, sports, and in school. The objectives are to determine the effect of the trauma when a child has experienced or witnessed an act of violence and to refer the child or youth for counseling, school violence programs, or other mental health services, as needed.

Points to remember regarding violence as a health concern include:

- Assessment of risk of violent behavior and past exposure to violence.
- Violence prevention education.
- Counseling for children or youth who have been abused or witnessed abuse of others.

Programs that address bullying and teach conflict resolution skills and peer mediation are available in most communities and schools. Be familiar with the prevention programs (e.g., domestic violence programs) in your area as resources for children affected by and/or involved in violence.

#### Suicide

Young people often give clues to peers, teachers, and foster parents or other adults of their intent to commit suicide. Therefore, it is important that all staff and caregivers be aware of behavioral clues that may suggest suicidal behavior. Some behavioral and informational indicators are:

- Previous suicide attempts.
- Signs of depression and undue stress.
- Threats of suicide (verbal or written).
- Isolation/withdrawal.
- Any self-injurious behavior.
- Dramatic changes in behavior (e.g., use of drugs and/or alcohol; school failure or truancy).
- Low self-esteem or extensive self-criticism.
- Giving away of personal belongings.

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When a young person in the community has committed suicide, there is a heightened possibility that others may “copy” the same behavior. When a community experiences this phenomenon, communication and coordination among various service providers may be helpful in providing grief and loss and prevention services.

Be familiar with your agency’s intervention procedures for handling suicide attempts and threats or talk of suicide. Caregivers should be trained in and familiar with these procedures. Staff training should include screening of foster children for risk of suicide, recognition of suicidal behaviors, suicide prevention, need for enhanced supervision, and referral to mental health services.

### Child and Adolescent Sexual Offenders/Reactors

Agencies should train staff periodically on the assessment and treatment of child and adolescent sexual offenders and sexual abuse reactors. Child and adolescent sexual abusive behavior covers a continuum including mutually engaging in adult sexual behavior and being sexually aggressive or abusive to others. Children identified as sexual abuse reactors have been abused in some way and are reacting in sexually inappropriate ways. Areas for training and development include:<sup>16</sup>

- Developing a core of specially trained foster parents who care for sexually abused and/or sexually aggressive children. In cases where children who have been placed in regular foster homes turn out to be sexually abused or sexually aggressive, it is recommended that more experienced foster parents mentor the less experienced foster parents.
- Identifying and developing relationships with clinicians who specialize in work with sexually abused children in foster care. Therapists who specialize in treating sexually abused children may need training in working with children in foster care.
- Accomplishing teamwork among caseworkers, therapists, and other mental health professionals for treating these children.
- Identifying placement settings that are appropriate to address the safety needs of the children. This includes looking at the layout of bedrooms, lighting, and bathroom facilities, as well as supervision practices. Consider whether the setting provides spaces where it may be difficult for adults to supervise children’s activities.
- Integrating strategies for involving the birth families into treatment approaches. Reunification is more difficult to achieve if the birth family members have not been involved closely in sexual abuse treatment. In particular, treatment for the sexually aggressive child in foster care who is transitioning back to the community needs to be developed in conjunction with the family or discharge resource and local mental health providers.

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<sup>16</sup> Sally G. Hoyle, *The Sexualized Child in Foster Care* (Washington, D.C.: CWLA Press, 2000), pp. 97-99.

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To address the needs of this population, topics to cover in staff training include, at a minimum:<sup>17</sup>

- Recognizing indicators of sexually abusive behaviors.
- Conducting initial screening and informal assessments to identify children for referrals for clinical assessments.
- Communicating with professionals who conduct clinical assessments.
- Recommending the appropriate level of care to meet all the needs of the child, and the child's family, in determining treatment.



### Health Care Coordination Activities

Develop a library of materials for staff, including books, videotapes, foster parent and staff training materials, and therapeutic books on sexual abuse for children. Identify sources of funding for staff and foster parents to attend conferences on child sexual abuse. Information and materials gathered at conferences can help build the library and provide information about new developments in the field. Staff will also gain information on new developments by attending meetings of local chapters of the organizations listed in section 5, Resources.

### General Principals for the Treatment of Juvenile Sexual Offenders<sup>18</sup>

- Juveniles are best understood within the context of their families and social environments.
- Assessment and treatment of juveniles should be based on a developmental perspective, should be sensitive to developmental change, and should be an ongoing process.
- Assessment and treatment should include a focus on the youth's strengths.
- The development of sexual interest and orientation is dynamic. The sexual interests of youth can change over the course of adolescence and this is the period when sexual orientation immerses.
- Youth who have committed sexual offenses are a diverse population. They should not be treated in a "one-size-fits-all" approach.
- Treatment should be broad-based and comprehensive.

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<sup>17</sup> Welfare Research, Inc., *Resource and Referral Guidebook for the Assessment and Treatment of Adolescent and Pre-Adolescent Sexual Abusers and Sexual Abuse Reactors* (NYS Office of Children and Family Services, 1998), p. 42.

<sup>18</sup> Michael H. Miner, et al. *Standards of Care for Juvenile Sexual Offenders of the International Association for the Treatment of Sexual Offenders*. (International Association for the Treatment of Sexual Offenders, 2006), p. 2-5. <http://www.iatso.org/care/MinerSOT3-06.pdf>

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- Labels can be more iatrogenic in children and adolescents than in adults. The juvenile and his/her family/primary care-giving system should be treated with respect and dignity. (**Note:** Iatrogenic means “Induced in a patient by a physician's activity, manner, or therapy.” In this context, the use of labels such as deviant or perverted by adults working with the youth is inherently harmful.)
- Sexual offender registries and community notification should not be applied to juveniles.
- Effective interventions result from research guided by specialized clinical experience, and not from popular beliefs, or unusual cases in the media.

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### 6 Resources

#### Bridges to Health (B2H)

<http://www.ocfs.state.ny.us/main/b2h/>

The B2H website provides comprehensive information on all aspects of the program, including links to forms and the B2H Program Manual.

#### HIV-Related Services

##### Information

New York State Department of Health HIV/AIDS section has extensive resources, including materials in English and Spanish on talking to children about HIV:

<http://www.health.state.ny.us/diseases/aids/index.htm>.

*Caring for Children with Special Needs* is written for parents, foster parents, and other caregivers raising infants, children, and adolescents with HIV. This resource was developed collaboratively by DOH and OCFS. To receive a copy, call 518-474-9866; or download it from

<http://www.nyhealth.gov/diseases/aids/resources/child/index.htm>.

##### HIV Counseling and Testing

New York State Department of Health: HIV/AIDS Counseling/Testing Hotline (800-962-5065); or <http://www.health.state.ny.us/diseases/aids/testing/>

In New York City: Pediatric AIDS Unit (PAU) (212-341-8943) of the NYC Administration for Children's Services (ACS).

##### Pediatric and Adolescent HIV Guidelines

For information on the guidelines of The New York State Department of Health AIDS Institute, go to [www.hivguidelines.org](http://www.hivguidelines.org), and click on Clinical Guidelines. The site provides information about HIV screening, testing, diagnosis, and treatment.

#### **The AIDS Treatment Data Network**

611 Broadway

Suite 613

New York, NY 10012

800-734-7104 (NYS only)

<http://www.atdn.org>

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The Network is a national, not for profit that provides case management, treatment and care access information, advocacy and counseling, education, and other services for people with HIV or chronic hepatitis.

### **Newborn Screening Program**

For more information about this New York State Department of Health program, go to <http://www.wadsworth.org/newborn>.

## Reproductive and Sexual Health

### Planned Parenthood

New York City: <http://www.plannedparenthood.org/nyc/>

Mid-Hudson Valley: <http://www.plannedparenthood.org/mid-hudson-valley/>

Mohawk-Hudson: <http://www.ppmhchoices.org/>

Northern NY: <http://www.ppny.org/>

Rochester/Syracuse: <http://www.pprsr.org/home/>

Western NY: <http://www.ppwny.org/>

Southern Finger Lakes: <http://www.plannedparenthood.org/ppsfl/index.htm>

Upper Hudson (Albany): <http://www.plannedparenthood.org/uhpp/>

### Information for Youth

**Note:** The following sites are listed so that caseworkers and caregivers can give youth reliable sites where they can get their questions answered.

#### **Advocates for Youth** ([www.advocatesforyouth.org](http://www.advocatesforyouth.org))

Helps young people make informed and responsible decisions about their reproductive health and sexual health. Site focuses on many social and political issues. Also available in Spanish and French.

#### **I Wanna Know** ([www.iwannaknow.org](http://www.iwannaknow.org))

Provided through the American Social Health Association. Answers questions about teen sexual health and sexually transmitted diseases, including puberty, “sex on the brain,” prevention, and a parent’s guide.

#### **It’s Your (Sex) Life** ([www.itsyoursexlife.org](http://www.itsyoursexlife.org))

Provided through Kaiser Family Foundation. A teen’s guide to safe and responsible sex; topics include pregnancy and contraception, HIV/STDs, and communication.

#### **Sex, Etc.** ([www.sexetc.org](http://www.sexetc.org))

The Network for Family Life Education, State University of New Jersey at Rutgers, publishes this print and web-based newsletter written by teens for teens. Site covers a wide variety of sex-related topics, including girl’s health, guy’s health, GLBTQ, teen parenting, abortion, adoption, and body image.

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### **Teenwire** ([www.teenwire.org](http://www.teenwire.org))

Provided through Planned Parenthood Federation of America. Site addresses a variety of teen issues, interactive contraceptive information, sexuality, and relationship information.

### **KidsHealth** ([www.kidshealth.org/teen](http://www.kidshealth.org/teen))

Provided through the Nemours Foundation, Center for Children's Health Media. Offers comprehensive overall health information for teens, including body, mind, food and fitness, school and jobs, drugs and alcohol, sexual health, and answers and advice.

### **New York Civil Liberties Union**

On the website <http://www.nyclu.org/>, select Resources – Know Your Rights. Information on reproductive rights is available.

### **Statewide School Health Services Center** (<http://www.schoolhealthservices.org/>)

43 Turner Drive  
Spencerport, NY 14559  
585-349-7630

The New York Statewide School Health Services Center (SSHSC) is a statewide technical support center funded through the Student Support Services Team of the New York State Education Department. The mission is to promote the health, learning, and overall well-being of all students, thereby strengthening and improving academic performance. The vision is to ensure that school health services are effective in addressing the health and safety needs of students by providing leadership and direction to school health professionals, parents, school districts, and community organizations to provide the critical linkage between health and student achievement.

## Pregnancy Services —

### Programs of the Department of Health

For a listing of providers in your area for the following programs, see the Department of Health website on Women's Health Issues: <http://www.health.state.ny.us/nysdoh/perinatal/en/index.htm>.

**Growing Up Healthy Hotline** – This toll-free hotline (1-800-522-5006) operates 24 hours a day, seven days a week, and provides information and referral for individuals, including teens, about pregnancy care services, family planning, health care, nutrition, and other health and human services. Information is available in English, Spanish, and many other languages.

**Prenatal Care Assistance Program (PCAP)** – A comprehensive prenatal care program that offers complete pregnancy care and other health services to women and teens who live in New York State and meet certain income guidelines. (Women are eligible for services up to 200% of the federal poverty level.) PCAP offers routine pregnancy check-ups, hospital care during pregnancy and delivery, full health care for the woman until at least two months after delivery, and full health care coverage for the baby up to one year of age.

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**Medicaid Obstetrical and Maternal Services (MOMS) Program** – This program provides complete pregnancy services in areas of the state where PCAP health centers are not located. Medical services are provided in private physicians' offices with other necessary services (nutrition, social work, etc.) being provided by a Health Supportive Services Program (HSSP). MOMS physicians are connected with a HSSP to ensure all women receive complete pregnancy care.

**Comprehensive Prenatal Perinatal Services Network** – The Networks are community-based organizations whose purpose is to organize the perinatal (pregnancy, delivery, post delivery and infancy) service system at the local level to improve pregnancy outcomes and promote better children's health. Networks accomplish this through working with a Consortium of local health and human service providers and consumers of services that helps the Networks identify and address issues. There are currently 15 Networks across the state that target women at highest risk for poor pregnancy outcomes.

**Community Health Worker Program (CHWP)** – The CHWP provides one-on-one outreach, education, and home visiting services to pregnant and parenting women and families at highest risk for poor health outcomes, particularly low birth weight infants and infant mortality (infant deaths). Services are provided by paraprofessionals who live in the area they serve and are trained to provide referrals for a wide range of services, and to provide support and assistance for families trying to obtain needed services, including accompaniment to scheduled visits when needed. There are currently 23 Community Health Worker Programs throughout the state.

**Perinatal Regionalization Program** – Perinatal regionalization ensures that there are hospitals that can provide a full range of services for pregnant women and their babies in a geographic region. This means parents-to-be can be sure that there are hospitals near where they live that can provide everything from a basic, uncomplicated delivery to those that can serve mothers and babies with the most complex, critical problems.

**Breastfeeding Promotion Program** – The program provides training and guidelines to encourage more mothers to breastfeed and to get them to breastfeed longer.

## Services for GLBTQ Youth

**Note:** The following sites are listed so that caseworkers and caregivers can give youth reliable sites where they can get their questions answered.

*GLBTQ: The Survival Guide for Queer and Questioning Teens* by Kelly Huegel, Free Spirit Publishing, 2003 (paperback).

GLBT National Help Center: <http://www.glnh.org/index2.html>

GLBT National Youth Talkline 1-800 246-7743. Hours: Mon-Fri 8 pm-midnight Eastern time. E-mail: [youth@GLBTNationalHelpCenter.org](mailto:youth@GLBTNationalHelpCenter.org). The GLBT National Youth Talkline provides telephone and e-mail peer-counseling, as well as factual information and local resources for cities and towns across the United States.

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“We Are...GLBTQ,” a video co-produced by Washington State's Department of Social and Health Services Children's Administration and Department of Information Services, sheds light on the lives of GLBTQ youth who find themselves in the state child welfare system. It is used in Washington State to train foster parents and kinship caregivers. For more information, contact the Communications Division at 360-902-8007. The discussion guide may be downloaded from: <http://www1.dshs.wa.gov/pdf/ca/We%20Are%20GLBTQ%20Discussion%20and%20Resource%20Guide.pdf>.

*CWLA Best Practice Guidelines: Serving LGBT Youth in Out-of-Home Care*, 2006.  
<http://www.lsc-sf.org/publications/bestpracticeslgbyouth.pdf>

*Definitions of Sexual Orientation and Gender Identity* (from *Practice Brief: Providing Services and Supports for Youth who are Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex or Two-Spirit*, Spring 2008. Georgetown University)  
<http://www11.georgetown.edu/research/gucchd/nccc/documents/lgbtqi2s.pdf>

**Lesbian:** Females who are emotionally and sexually attracted to, and may partner with, females only.

**Gay:** Males who are emotionally and sexually attracted to, and may partner with, males only. “Gay” is also an overarching term used to refer to a broad array of sexual orientation identities other than heterosexual.

**Bisexual:** Individuals who are emotionally and sexually attracted to, and may partner with, both males and females.

**Transgender:** Individuals who express a gender identity different from their birth-assigned gender.

**Intersex:** Individuals with medically defined biological attributes that are not exclusively male or female; frequently “assigned” a gender at birth, which may differ from their gender identity later in life.

**Two-Spirit (2-S):** A culture-specific gender identity for Native Americans (American Indians or Alaska Natives) with homosexual or transgendered identities. Traditionally a role-based definition, two-spirit individuals are perceived to bridge different sectors of society (e.g., the male-female dichotomy, and the Spirit and natural worlds).

**Sexual Minority:** The term “sexual minority” is inclusive, comprehensive, and sometimes used to describe youth who are LGBTQI2-S. However, it may have a negative connotation because minority suggests inferiority to others.

**Other Terms:** Youth also may use other terms to describe their sexual orientation and gender identity, such as homosexual, queer, gender queer, non-gendered, and asexual. Some youth may not identify a word that describes their sexual orientation, and others may view their gender as fluid and even changing over time. Some youth may avoid gender-specific pronouns.

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### Trauma

National Child Traumatic Stress Network: <http://www.nctsn.org/>

OCFS provided teleconference training on trauma on May 1, 2008 and June 25, 2008. In addition to these programs, a folder of materials and resources on trauma were provided to each agency. Check with your staff development coordinator.

### Suicide

National Suicide Prevention Lifeline: 800-273-TALK (8255); TTY line: 800-799-4889

Voice-Diagnostic Interview Schedule for Children (V-DISC) is a comprehensive, structured interview that uses DSM-IV criteria to screen for more than twenty mental health disorders as well as suicidal ideation found in children and adolescents. The V-DISC is a self-administered test. For more information, see Columbia University: <http://www.promotementalhealth.org/overview.htm> and NYS Division of Probation and Correctional Alternatives: <http://dpca.state.ny.us/technology.htm>.

SPEAK (Suicide Prevention Education Awareness Kit) is an initiative of the Office of Mental Health. <http://www.omh.state.ny.us/omhweb/speak/index.htm>

### Assessment and Treatment of Child and Adolescent Sexual Offenders

*Identifying and Treating Youth who Sexually Offend: Current Approaches, Techniques and Research* by [Robert Geffner](#) (Editor), [Kristina Crumpton Franey](#) (Editor), [Teri Geffner Arnold](#) (Editor), [Robert Falconer](#) (Editor). Haworth Press, 2004. Co-published simultaneously as *Journal of Child Sexual Abuse*, Volume 13, Numbers 3/4 2004.

#### **Association for the Treatment of Sexual Abusers (ATSA)**

4900 S.W. Griffith Drive, Suite 274  
Beaverton, OR 97005  
503-643-1023  
[www.atsa.com](http://www.atsa.com)

Incorporated in 1984, the Association for the Treatment of Sexual Abusers is a nonprofit, interdisciplinary organization. ATSA was founded to foster research, facilitate information exchange, further professional education, and provide for the advancement of professional standards and practices in the field of sex offender evaluation and treatment. ATSA is an international organization focused specifically on the prevention of sexual abuse through effective management of sex offenders. The organization convenes an annual conference and publishes a journal and other documents.

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### **New York State Association for the Treatment of Sexual Abusers & New York State Alliance of Sex Offender Treatment Providers**

P.O. Box 3115  
Albany, NY 12203-3115  
<http://www.nysatsa.com/>

The Alliance is a voluntary public and private sector initiative established in 1988 to promote the enhancement and quality of services available for sex offenders with the goal of keeping communities safe. The Alliance, which is sponsored by membership dues, presents regional trainings and an annual statewide conference. The organization also sponsors the New York State chapter of the Association for the Treatment of Sexual Abusers (ATSA) and publishes a quarterly newsletter.

### **The Safer Society Foundation, Inc.**

(formerly The Safer Society Program)  
P.O. Box 340  
Brandon, VT 05733-0304  
802-247-3132  
[www.safersociety.org](http://www.safersociety.org)

The Safer Society Foundation, Inc., a nonprofit agency, is a national research, advocacy, and referral center on the prevention and treatment of sexual abuse. Founded in 1964 as the Prison Research Education Action Project (PREAP) by Fay Honey Knopp, PREAP evolved into the Safer Society Program in 1985, and became the Safer Society Foundation, Inc. in 1995. The Safer Society Foundation, Inc. provides a variety of services related to the prevention and treatment of sexual abuse.

The Safer Society Press, a small nonprofit press operated by the Safer Society Foundation, Inc., publishes relevant research, studies, video and audio tapes, and books that contribute to the development of sexual abuse treatment, sexual abuse prevention, emerging topics, and developments in the field.

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### *Chapter Four*

## Health Care Coordination

In response to the legal mandate for social services agencies to provide for the necessary physical, emotional, and developmental health of children in foster care, and in recognition that current practice does not consistently overcome barriers to high quality, comprehensive care for this vulnerable and needy population, the Office of Children and Family Services strongly recommends the implementation of health care coordination for all children. Health care coordination activities support the child's treatment plan and permanency goal by focusing on health issues, coordinating health services, and integrating health concerns into all aspects of safety, well-being, and permanency.

*(See Appendix B for the guidance paper, Health Care Coordination for Children in Foster Care: Approaches and Benefits (09-OCFS-INF-01).*



Sections in this chapter include:

1. Definition of health care coordination
2. Implementing health care coordination
3. Activities of health care coordination
4. Resources

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### 1 Definition of Health Care Coordination

The role of health care coordination is to create a locus of responsibility for all aspects of health services for each child in foster care. Health care coordination supports the provision of assessment, treatment, and follow-up services in accordance with established health care standards.

The health care coordination function can be compared to the role of a parent who has a child with special needs. The parent would be diligent in his or her efforts to choose health care providers carefully, follow up on all appointments and referrals to specialists, support the recommended treatment plan, advocate for the child when necessary, arrange transportation for appointments, and accompany the child to appointments. The parent would also address payment for the health care providers, learn more about the child's medical needs, assist the health care providers in obtaining the records they need, share information among health care providers as appropriate, and encourage communication among all who have a role in the child's health care. Because of the significant, serious health needs of children in foster care and the multiple layers of tasks and people involved, this level of attention and involvement is necessary to facilitate health services for these children.

There are many barriers to overcome in coordinating health services for children in foster care. The temporary nature of foster care makes providing the child a medical home and the timely transfer of medical information a formidable task. Communication and confidentiality issues are always a concern among the parties with shared responsibility for these children: caseworkers, foster parents and birth parents, as well as multiple health care providers. Routine tasks such as obtaining copies of medical records can be time-consuming and problematic. Health care coordination breaks down these barriers through activities that coordinate and support health services for the child.

The case management and health care coordination processes need to be well integrated to provide a seamless delivery of services to the child. Teamwork and communication are key elements of effective health care coordination. A health care coordinator plays a supportive role on the treatment team, advising team members of the immediate and ongoing health needs of the child, and improving the health outcomes for children.

Health care coordination entails a variety of activities, including identifying health care providers and arranging appointments, facilitating the completion of assessments, creating an agency health record for each child, coordinating a health treatment plan that is integrated into the child and family service plan, and providing assistance to agency staff and caregivers around health issues. These tasks are described in more detail below.

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### Benefits of Health Care Coordination

OCFS supported a four-year health care coordination pilot in eight sites from 2003 to 2007 (a ninth site operated for one year only). The program evaluation documented the following program benefits:<sup>1</sup>

- Higher rates of initial assessment completion and timeliness. Following establishment of their care coordination programs, sponsored agencies significantly increased the number of children under their care who received initial physical, dental, mental health, developmental, and substance abuse assessments within state recommended time frames.
- Better identification of health care needs. Children were more likely to have documentation of physical, mental health, developmental and educational problems diagnosed and/or identified by a health care professional.
- Improved documentation of access to health care professionals. Documentation of well child care, preventive dental exams, mental health therapy, Individual Education Plans, and Early Intervention service receipt was significantly higher for children in care coordination.
- Increased communication with service providers and caregivers. Care coordination staff had more contact with birth parents, foster parents, and service providers about a child's health-related needs than foster care staff working without health care coordination.

In addition to the evaluation findings, the pilot sites reported that enhanced attention to health services resulted in benefits at the institutional level. Participants were motivated to shift their broader agency culture to a more integrated, health-oriented model of service delivery. As a result, some agencies designed new mechanisms for gathering and tracking health care information, developed assessment protocols for new admissions, enhanced parent education services, established agency-community provider partnerships, and established or improved on-site health facilities. Many agencies noted that the project was instrumental in identifying service gaps and reducing duplication of effort. Care coordination staff also acted as a model for other agency staff, piloting and sharing new ways for addressing health issues.

Agencies found that health care coordinators served as an additional support to caseworkers and birth parents alike. Caseworkers became comfortable with care coordinators addressing all aspects of health care. Birth parents perceived the care coordinators as a nonthreatening resource within the agency. Trust was built between birth parents and care coordinators as both focused on the child's well-being and worked together to understand and support the child.

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<sup>1</sup> NYS Office of Children & Family Services. *The New York State Care Coordination Pilot Project: Process & Impact Evaluation Study Findings* (March 2007). Available at <http://www.ocfs.state.ny.us/main/reports/>.

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## 2 Implementing Health Care Coordination

Health care coordination will look different across New York State because of the variety of health service delivery models in our agencies and local districts. In planning implementation, agencies must consider a variety of factors, including available resources. Two important factors to consider are how health services are delivered to children in foster care and how the agency currently monitors or oversees the services.

### Health Services Delivery

Children in foster care receive medical care in a variety of ways. Methods of communication and collaboration between the provider and care coordinator differ across these models. Here are some typical health delivery models.

- **Community providers.** Children in foster homes receive their care from providers within the community. These may include doctors and clinics that the foster parents or agency know to be reliable and familiar with the needs of children in foster care. Typically, the foster parent accompanies the child to the appointment, keeps track of appointments, and informs the caseworker about the outcome of the appointment.
- **Agreements with providers.** The LDSS or voluntary agency may have agreements or contracts with community or hospital-based providers to serve children in foster care. For example, a specific psychologist may contract with the agency to conduct all initial mental health assessments, or a mobile dental van may be engaged on a regular basis.
- **Agency clinic.** The LDSS or agency may operate its own medical clinic for children in care. Children may still use community or hospital providers for specialty care.

### Oversight

The coordination, monitoring, and oversight of health services are dependent on the staffing model at the agency or LDSS with whom the child is placed, as well as the level of care. Identifying individuals who are currently carrying out the care coordination activities is an important step in determining what changes, if any, will take place.

- Foster parents may play a major role by scheduling appointments, accompanying the child to appointments, and advocating for specialty services. The foster parents keep the agency informed of health-related activities.
- The case manager or caseworker may be responsible for arranging and reminding caregivers of appointments, assisting with transportation, and obtaining copies of records.

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- The agency may employ health care coordinators and/or nursing staff that track attendance at appointments and review records to determine what additional services are needed. This model is often employed in congregate care settings.

### Critical Elements

After consideration of the health services delivery model, current practice, and resources, the agency or LDSS may choose to delegate some of the health care coordination activities described in section 3 to designated staff. It is recommended that a lead person with a health background be identified to provide or assist with health care coordination. This individual may be an RN, LPN, psychologist, CSW, or social worker with experience in addressing the physical and mental health needs of children in foster care. If the individual does not have training or experience in a health field, health practitioners should be identified to provide technical assistance.

Though the model of practice will vary, OCFS's pilot project identified characteristics that were critical to the success of health care coordination.

1. Designation of care coordinator. The single most important factor in the success of health care coordination is the designation of an individual whose sole responsibility is care coordination. That person is freed from the many tasks, concerns, and responsibilities that foster care staff must address. The care coordinator can simply concentrate on the child's well-being.
2. Organizational support. The decision to incorporate health care coordination for children in foster care must be supported by administrators and managers throughout the organization.
3. Clarification of roles. Staff must understand which activities will now be performed by the care coordinator. Among other things, the care coordinator's role in service plan development and review and in working with foster and birth parents should be clearly defined.
4. Team meetings. Pilot agencies found that regular team meetings with health care coordinators, caseworkers, supervisors, and in-house medical staff were instrumental in sharing information and fully integrating health issues into the child's service and permanency plans.

Regardless of the agency's ability to assign dedicated staff to health care coordination, the activities described in the next few pages should be carried out for each child in foster care.

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### 3 Activities of Health Care Coordination

#### Information Management

A primary task of health care coordination is the documentation of health information for each child. This information is critical in the planning and facilitation of health services (*see Appendix A for a sample Health Care Coordination and Treatment Plan form*). Several activities are included:

- Establishing and maintaining a health file for the child. Each child in foster care must have an individual health file in the case record<sup>2</sup> (*see Chapter 8, Maintaining Health Records*).
- Obtaining medical consent as needed (*see Chapter 6, Medical Consents*).
- Gathering health information.<sup>3</sup> This includes current and past records from medical providers, as well as health information from the child, family, caregivers, schools, other agencies, etc. The information becomes a part of the health file. If necessary, the Medicaid unit of the LDSS can access records of claims paid on individual children through the eMedNY system. This will help identify past providers.
- Recording current and ongoing health status and activities. This involves adding a note or report into the health file when a service is received, and entering necessary data into CONNECTIONS. The agency or LDSS may also use in-house forms or systems to track medical activities.
- Sharing health information as appropriate among the child's health care providers, treatment team, and family members.
- Controlling access to the child's health file (*see Chapter 7, Confidentiality of Health Information*).

#### Accessibility to Services

It is the role of health care coordination to help each child access necessary health services. The following tasks are included:

- Facilitate the provision of appropriate medical insurance.

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<sup>2</sup> 18 NYCRR 441.22(k); 18 NYCRR 428.3(b)(2)(ii).

<sup>3</sup> 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

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- Communicate with the LDSS staff who conduct Medicaid eligibility determinations to confirm they are completed in a timely manner. This includes initial determination, recertification, and continuous coverage after the child is discharged from care.
- Provide agency protocols for payment of medical services to the child’s foster parent or caregiver.
- Provide agency protocols for payment of medical services to health care providers.
- If payment for health services is denied, inquire as to whether the denial was appropriate. If necessary, appeal the decision, following the process set forth by the insurer.
- Address payment issues that may arise with service providers. The availability of a point person to troubleshoot billing concerns is essential in building trust and cooperation with health providers.
- Assist in the identification of providers to conduct initial assessments, as well as specialty care.
- Establish a medical home for children in foster care. A medical home is the central site for provision and coordination of health services as well as an essential repository for health information. Ideally, the child should keep the same medical home throughout foster care and upon discharge. If the child had a medical home when he or she entered care, efforts should be made to continue with that health care provider. <http://www.medicalhomeinfo.org/>

A medical home is not a building, house, or hospital, but rather an approach to providing health care services in a high-quality and cost-effective manner. Children and their families who have a medical home receive the care they need from a pediatrician or physician (pediatric health care professional) whom they trust. The pediatric health care professionals and parents [or other caregivers] act as partners in a medical home to identify and access all the medical and non-medical services needed to help children and their families achieve their maximum potential. The American Academy of Pediatrics believes that all children should have a medical home where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. (*American Academy of Pediatrics*)

- Locate, nurture, and develop agreements with health care providers. An up-to-date list of providers’ names, phone numbers, addresses, and specialties is particularly helpful for caseworkers and caregivers (*see Chapter 9, Working with Community Health Care Providers*).
- Assist in the identification and development of appropriate placement resources for children with complex health concerns. These efforts assist the agency in making good placement matches, resulting in increased stability and fewer moves for children in foster care.
- Seek out the best health care available for the children in your agency’s care. Identify and provide supports needed by caregivers to advocate effectively for the child.

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### Coordination of Health Services

In the first three chapters of this manual, required and recommended health services are outlined for children in foster care. Facilitating the provision of these services is the role of health care coordination. This includes setting up appointments, notifying the caregiver of the time, arranging transportation as needed, and communicating with the caregiver around the child's medical appointments. Here are the specific areas that will benefit from health care coordination:

- Completing initial assessments. As assessments in five areas (medical, dental, mental health, developmental, and substance abuse) should be completed for all children in foster care, it may be helpful to identify a group of providers in your area to routinely conduct these assessments.
- Developing a comprehensive, coordinated care plan based on the assessment results. The findings, therapies provided, and follow-up recommendations are reviewed and coordinated into a care plan, which becomes a part of the child's health file. The plan is developed cooperatively with the child's treatment team.
- Ongoing routine and specialty care. Health care coordination activities (1) support the caregivers as necessary in following the AAP periodicity schedule for routine care, and (2) promote the required and recommended medical activities outlined in this manual.
- Addressing barriers to provision of health services. Barriers may include issues such as transportation, missed appointments, child's refusal to take necessary medication, lack of availability of services, or the need to advocate for a special treatment. Care coordination is an effective tool in addressing whatever stands in the way of essential health care.
- Being the communication "point person" for providers.
- Incorporating the child's care plan into the Family Assessment and Service Plan. Support the child's treatment team in understanding the child's health issues and integrating health-related outcomes and activities into the service plan.
- Assisting the treatment team, caregiver, child, and family in understanding, supporting, and implementing the care plan.
- Engaging the birth family by explaining the child's health needs and encouraging their participation in appointments and treatments.
- Arranging treatment team meetings that address the child's health issues. Meetings are used to share information and strategize activities to support the child's health and may include health care providers, school staff, caregivers, the child, and the family, as appropriate. These meetings can be especially critical if the child has complex medical needs or significant barriers to health care have arisen.
- Compiling the child's health information for use in court hearings.

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### Discharge Planning

It is highly beneficial to maintain continuity of health care services when the child is discharged from foster care. Health care coordination addresses the following issues:

- Discharge exam. A discharge exam is recommended for all children leaving foster care. It is required for any child discharged to another planned living arrangement with a permanency resource who has not had a medical exam within one year prior to discharge.<sup>4</sup>
- Continuous Medicaid coverage. Children discharged from foster care are generally eligible for 12 months of Medicaid coverage. LDSS staff responsible for determining Medicaid eligibility will need to complete the appropriate determinations in a timely manner to continue the child's coverage. The local DSS should have internal processes in place for communicating changes in the child's living arrangements, including updating the child's address.
- Standing appointments, treatments, and medication. Inform the child and parent or discharge resource of any appointments that have been scheduled. Be sure that medications, prescriptions, and information about other treatments (e.g., a special diet) have been provided upon discharge.
- Medical home. The child should continue with the same medical home and specialty providers after discharge from care. If this is not possible, assist the child and parent or discharge resource to identify providers.
- Information for the child or parent/discharge resource. The child (if discharged to another planned living arrangement with a permanency resource) or the parent/discharge resource must be provided with a comprehensive health history. The parent/discharge resource should be fully informed of the child's health issues as well as the importance of comprehensive and periodic medical assessments and follow-up treatment.<sup>5</sup>
- Self-care skills. If the child is discharged to another planned living arrangement with a permanency resource, the child should have sufficient knowledge and skills to address his or her own medical needs and seek either urgent or routine care as needed.
- Medical records. A copy of the child's comprehensive health history must be provided to the child's health care provider.<sup>6</sup>

*(See Appendix A for a sample Health Discharge Summary form.)*

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<sup>4</sup> 18 NYCRR 441.22(n).

<sup>5</sup> 18 NYCRR 441.22(o)(1)(2).

<sup>6</sup> 18 NYCRR 441.22(o)(5).

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### Activities That Benefit the Agency

Depending on the size, capacity, and experience of the staff responsible for health care coordination, additional support may be provided to the agency in a variety of ways. These include:

- Coordination of training efforts around health topics. Both caseworkers and caregivers need information about the unique health care needs of children in foster care. Community health providers may also appreciate information on child welfare issues to help them understand the children they are serving. Health care coordination serves a central role in identifying, arranging, and tracking the provision of health training and education.
- Consultation and advocacy on special medical issues.
- Assistance and support for the caseworker around special services such as Early Intervention (EI), Bridges to Health (B2H), or the Committee on Special Education (CSE). More information on these services can be found in the manual *Working Together: Health Services for Children in Foster Care*. [http://www.ocfs.state.ny.us/main/sppd/health\\_services/manual.asp](http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp)
- Documentation and update of agency protocols and procedures. These may address topics such as confidentiality, maintenance of the child's medical record, billing procedures for providers and emergency rooms, protocols around the use of psychiatric medications, or the development of specialized forms or systems for tracking health activities.
- Monitoring and evaluation of the overall quality of health services provided to children in foster care. This information can prove valuable in overcoming barriers to optimal health services. It can also inform management and local government on the strengths and areas for improvement in the local health care delivery system. State, county, and voluntary agencies should cooperate in the development and implementation of Quality Improvement Programs for health services for children in foster care.

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### 4 Resources

*The New York State Care Coordination Pilot Project: Process & Impact Evaluation Study*, March 2007. <http://www.ocfs.state.ny.us/main/reports/>

The National Center of Medical Home Initiatives. <http://www.medicalhomeinfo.org/>

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### *Chapter Five*

## Medication Administration and Management

Whether used to alleviate the pain of a toothache or to stabilize a serious medical condition like diabetes, medication can be critical to the functioning and well-being of children in foster care. The proper administration of medication is always important; given that children in foster care are placed outside their own homes, it becomes even more crucial to manage and document the activity. Storage and disposal of medication are other issues that must be addressed in a foster care setting. This chapter provides guidelines and instructions regarding medication for children in foster boarding homes and congregate care. The material is directed at casework and health staff who are managing foster care cases as well as health and non-health staff in congregate care facilities.



Sections in this  
chapter include:

1. The basics
2. Types of medication
3. Routes of administration
4. Who administers medication
5. Guidelines for administering medication
6. Special situations
7. Storage, inventory, and disposal of medication
8. Psychiatric medication
9. Controlled substances and congregate care
10. Resources

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### 1 The Basics

The purpose of medication varies depending on the child's medical condition and needs. It can be given to alleviate symptoms or manage medical or mental health conditions. When caregivers know the purpose of the prescribed medication, they may find it easier to comply fully with the health care provider's instructions. Children may also be more cooperative when they understand its purpose.

When children enter foster care, they may or may not be taking medications. When a child entering foster care is on medication, make note of the purpose and type of medication at the initial screening. At the initial medical examination, be sure that the health care provider reevaluates the prescription(s). If the medication is continued, caregivers must understand how to administer the medication, including the purpose, dosage, schedule, route, duration of use, and side effects and how to respond to potentially dangerous side effects. If a child is on multiple medications, it is crucial to discuss this with the primary care provider to assure that the medications are compatible and that they contribute to the child's overall treatment. The pharmacist is also an excellent resource for information on medication interactions.

Even if children enter foster care without medication, they will most likely need medication at some point while in placement. Caregivers are responsible for understanding and following directions given by the prescribing practitioner; it is important to review compliance with the prescribed medication during casework contacts. Stress, also, that medication cannot be discontinued unless ordered by the practitioner.

Make sure that caregivers know how to prepare for medical appointments in terms of medication:

- If blood work or other tests have been ordered, be sure that these are completed in the time frames directed by the practitioner.
- Bring all medications to the appointment, including over-the-counter items (such as vitamins) that the child has been taking.

### Filling Prescriptions

Ideally, all prescriptions should be filled at one pharmacy so that all medications are listed in one place. Caregivers will be able to get advice from a pharmacist who has the child's complete record at hand.

If your agency uses a Medicaid per diem, be aware that certain medications for children in foster care can be billed directly to eMedNY by the pharmacy. A list of these "carveout" prescriptions may be found on the Department of Health website:

[http://www.health.state.ny.us/health\\_care/medicaid/program/carveout.htm](http://www.health.state.ny.us/health_care/medicaid/program/carveout.htm)

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## 2 Types of Medication

General types of medication include:

- **Over-the-Counter (OTC) Medication** – Medications or substances that can be purchased commercially by individuals without a prescription. In congregate care, to minimize errors, OTC medications are best stocked in unit dose containers or packets.
- **Prescription Medication** – Any medication that requires a written prescription by a physician, dentist, nurse practitioner, or physician’s assistant. These medications are prescribed for specific individuals and should never be given to anyone else.
- **PRN Prescription Medication** – Any medication given only when necessary to alleviate symptoms, on an emergency or “as needed” basis, rather than on a routine basis (e.g., to relieve headache or menstrual cramps). PRN is the abbreviation for the Latin term “pro re nata,” which means “as needed.”
- **Psychiatric Medication** – Medication prescribed by a psychiatrist or other medical practitioner for the treatment of mental illness or the symptoms of mental illness (*see section 8, Psychiatric Medication*).
- **Herbal/Homeopathic Remedies and Diet Supplements** – These include a variety of substances that are used following traditional practices. They have not been reviewed or approved by the FDA for efficacy and safety and should not be used without the advice of a health care provider.

## Names of Medication

A medication may be known by three different names:

- **Chemical name** – the chemicals that comprise the medication; often long and difficult to pronounce.
- **Generic name** – often a simplified version of the chemical name that is *not* capitalized; generic drugs are often less expensive than brand name medications.
- **Brand name** – name owned by the manufacturer; the same medication may have different brand names if manufactured by different companies; the first letter of this name is capitalized.

For example: **Chemical name** = acetylsalicylic acid  
**Generic name** = aspirin  
**Brand name** = Bayer

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### Preparation Forms

Medicines are prepared for use in a variety of different forms to treat disease either locally (in a particular area or site) or generally (throughout the whole body or system). Listed below are common medicinal preparations:

- **Tablet and Caplet** – a solid dosage form containing medicine; it may vary in shape, size, weight, and color.
- **Capsule** – a special coating made for a single dose of a drug. For the oral route, the enclosure prevents the patient from tasting the drug. Time-release capsules allow the medication effects to continue at the same level over a long period of time.
- **Lozenge** – small, dry solid medicine, often pleasantly flavored, that is held in the mouth until it dissolves to slowly release the medication.
- **Liquid** – Sometimes medicine is dissolved in a fluid. It is best to use calibrated cups or medication cups (rather than teaspoons) for pouring and measuring liquids. Liquids come in different forms:
  - **concentrates** – liquid forms of medication in which the volume is decreased to increase the strength of the medication.
  - **suspensions** – solid particles in a liquid that must be shaken well before use.
  - **syrops** – thick, often flavored solutions with a sugar and water base that are particularly effective for masking the taste of the medication.
  - **elixirs** – liquid preparations that have an alcohol, sugar, and flavor base.
- **Suppository** – a semisolid substance for introduction into the rectum or vagina where it dissolves and is absorbed into the body. The medicine is commonly mixed with soap, glycerinated gelatin, or cocoa butter to form the suppository.
- **Inhalant** – a medication or compound that is nebulized (reduced to a fine spray) suitable for inhaling or drawing into the lungs. When used properly, inhalants should take effect immediately. Inhalants are most frequently prescribed for asthma.
- **Injection** – forcing of a fluid through a needle into a vessel or cavity or under the skin.

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### ■ Miscellaneous

- **cream** – a solid emulsion used to treat rashes, itching, drying, and fungus infections.
- **ointment** – a medicated, fatty, soft substance having antiseptic, cosmetic, or healing properties. Usually its base is petroleum jelly, lard, or lanolin to which the medication is added.
- **spray** – a jet of fine medicated vapor applied to an injured area or discharged into the air. Sprays and aerosols are effective methods for applying topical preparations without having to touch the skin while applying it. They are also effective for hard-to-reach places such as the throat.
- **powder** – fine particles of one or more substances that absorb moisture on the skin. Its medicinal purpose is to soothe irritated skin or reduce rubbing of adjacent irritating skin surfaces.
- **patch** – a piece of material affixed to the skin for transdermal applications. Medication is either placed on the patch, or the patch is pre-medicated and is absorbed into the skin.
- **lotion/shampoo** – commonly used as soothing applications to protect the skin and relieve rashes and itching. Some lotions have a cleansing action, while others have a drying or drawing action. To prevent increased circulation and itching, lotions should be patted on the skin instead of rubbed on. An example is Kwell® for treatment of head lice.

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### 3 Routes of Administration

Medication can be administered to the body in many different ways or routes as defined below:

- **Oral** – by mouth. Examples are Tylenol® and Motrin®.
- **Sublingual** – under the tongue, where it is absorbed rapidly into the mucous membranes (e.g., a nitroglycerin tablet prescribed for angina that is placed under the tongue for absorption).
- **Topical** – applied to the site for local action (e.g., corticosteroids and antivirals in lotion or cream forms).
- **Inhalation** – inhaled through the mouth or nose and absorbed through the lungs (e.g., over-the-counter nasal sprays, bronchodilators, and inhaled corticosteroids). Some of these substances can interact with prescription medication and cause unpleasant reactions.
- **Rectal/Vaginal** – for treating local infections or for medicines that can't be taken orally (e.g., anti-fungal for vaginal yeast infections or suppositories to suppress vomiting).
- **Transdermal** – a medicated adhesive patch is placed on the skin to deliver a specific dose of medication through the skin and into the bloodstream.
- **Injection:**
  - **Subcutaneous** – injection under the skin for rapid general action and for medication that cannot be taken orally (e.g., insulin).
  - **Intradermal** – injection into the skin (e.g., injection of PPD – purified protein derivative – for Mantoux Screening of Tuberculosis).
  - **Intramuscular** – injection into the muscle for general action, rapid effects and for medications that cannot be taken orally (e.g., antibiotics, hepatitis B vaccine).
  - **Intravenous** – injection into the vein to ensure immediate and adequate treatment in critically ill patients (e.g., antibiotics).

**Note:** Generally, only nurses give injections. In some instances (e.g., a child with diabetes), it may be appropriate for the child to self-administer injections with appropriate guidance and supervision.

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### 4 Who Administers Medication

Who administers medication depends on several factors, such as the child's age, ability to prepare and self-administer the medication, and willingness to do so. Generally, caregivers of young children will be responsible for knowing the medication schedule, verifying the correct dose, preparing the medication (e.g., removing a pill from a bottle, measuring liquid), and recording the information. Older children may be responsible for taking medication under the supervision of the caregiver.

When health staff are present in congregate care facilities, they should administer all medications. When health staff coverage is not available, childcare staff can supervise the self-administration of prescription and over-the-counter medications by children. However, all staff administering or supervising the self-administration of medication should be trained.

It is recommended that training include the following:

- An overview of medications commonly prescribed to children and the conditions they treat.
- Observation for medication effect.
- Agency procedures for observing and recording the self-administration of medication.
- Error prevention and remediation.
- Agency procedures for handling, storage, and disposal of medication.

There is no formal medication administration “certification” requirement for foster care childcare staff. There is a certification program for voluntary agencies licensed by the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD), so these agencies may actually have all staff certified in medication administration.

**Note:** Caregivers/staff of the same sex as the child or youth should administer certain types of medications such as vaginal creams, rectal suppositories, and antifungal sprays.

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### 5 Guidelines for Administering Medication

General guidelines for administering medication to children in foster care follow the “Five R’s of Medication”:

- Right Person
- Right Medication
- Right Amount/Dosage
- Right Route of Administration
- Right Time

Foster parents, as well as congregate care staff, will find these “rights” useful whenever they administer medication. The five R’s are reminders to administer medication thoughtfully and with attention (not in a hurry) and that doing so is a serious responsibility.

Be familiar with your agency’s policies and procedures for administering medication. Critical points in administering medication include:

- Knowing how to read the label, which should specify the child’s name, name of the drug, date, route of administration, dosage, frequency, time, directions for use, precautions, refills, and stop date.
- Verifying the information with the child, as appropriate.
- Making sure conditions are clean (e.g., hands washed, clean counter) and well lit.
- Using a medicine cup, dropper, or medication syringe when measuring liquids, not household utensils.
- Observing the child take the medication and swallow it completely.
- Storing the medication safely and as directed.
- Documenting the administration of medication per your agency’s policy.

### Side Effects

Caregivers need to be informed of the possible side effects of all medications. Review the drug information sheet from the pharmacy, and ask questions. A child may experience side effects from medication even if the desired effect occurs. Observe the child for any physical (e.g., allergies) or behavioral side effects during the first few hours and days following use of a new medication. If a child develops an unexpected or dangerous side effect, medical advice should be sought immediately (*see section 8, Psychiatric Medication*).

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### Medication Schedule/Recording

- Give caregivers the message that it is important to adhere to the dose and frequency prescribed for each medication. Many medications are not effective unless a certain level is maintained in the blood; missing a dose could have a harmful effect on the child's health. It is important to be consistent when giving medication.
- A medication log is a helpful tool, especially for children with complicated medication schedules (*see Appendix A for a sample medication log*). The log helps caregivers be consistent, complete, and accurate in the administration of medications. Record the date, time, dosage, and any relevant comments or observations in the child's medication log. These comments can be particularly useful in revealing patterns around the effect of the medication and the child's tolerance. Caseworkers should review the log and discuss medications during routine visits to the home. Agencies are encouraged to develop procedures and protocols around medication documentation.
- Encourage caregivers to keep a list of the child's medications to present to any medical or mental health provider. Urge caregivers to keep the list with them or in their car in case of emergencies.
- The Medication Administration Record (MAR) is used in institutional settings to record information about a child's medication.

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### 6 Special Situations

Situations may occasionally arise that require action, such as medication errors, refusal to take medication, and taking medication outside the foster home or facility.

#### Medication Errors

If an error in the administration of medication occurs, it is important to determine the type of error that occurred. Was the error procedural, such as giving the medication at the wrong time? Or was the error likely to be dangerous to the child, such as giving a medication to the wrong child? Look at the procedures that are currently in place and consider what could be done to prevent future errors. If the error is dangerous, contact the health care provider or Poison Control Center immediately. The phone number for the Poison Control Center (1-800-222-1222) should be prominently displayed in foster homes and congregate care facilities. *(See section 10, Resources, for a complete listing of Poison Control Centers and TTY/TDD phone numbers in New York State.)*

Examples of medication errors:

- Missed medication
- Wrong medication
- Wrong dose of medication
- Medication given at wrong time
- Medication given to wrong child
- Medication given via wrong route or method
- Discontinued medication given
- Outdated medication given
- Medication contaminated (e.g., dropped on the floor)

Concerning errors, advise foster parents to:

- Contact the Poison Control Center if an excess dose is suspected.
- Contact the health care provider or pharmacist immediately for advice.
- Observe the child for any possible effects.
- Contact the caseworker.
- Document any error (e.g., missed dose) in the medication log.
- When buying prescription medication, ask the pharmacist what to do when a child misses taking the scheduled dose.

In a congregate care facility, follow established procedures. Document the error in the MAR and report the missed dose to the designated staff person. Information about spilled or contaminated medication must be documented for inventory purposes. When a medication needs to be discarded, notify the designated staff person.

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The first action for a caregiver of a child who may have ingested a toxic substance is to consult with the local poison control center. The American Academy of Pediatrics has released a policy statement recommending that syrup of ipecac *not* be administered to induce vomiting. More information can be found at: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/5/1182>. Ask your agency medical director or consulting pediatrician for guidance on this matter.

### Child Refusal to Take Medication

Sometimes children express concern about taking a medication because they don't see the benefit, or they're tired of taking it, or they feel "different" from their friends by having to be on medication. Side effects that change the child's energy level or appearance can also make a child reluctant to comply with their medication regimen. Encourage caregivers to take these concerns seriously and address them before they reach the stage of refusing to take the medication.

Guidance to caregivers when a child refuses to take medication includes:

- Try to talk the child through it. Find out why he/she is refusing the medication. Stress the purpose and importance of taking the medication.
- Explain that the child can talk to the health care provider on the next visit.
- If the child still refuses, ask the mental health professional or health staff for help.
- If the child has a condition that requires medication (e.g., seizures, asthma), talk to a health professional to determine the appropriate course of action

See your agency's policies and procedures on children in congregate care refusing to take their medication.

➔ Tips on taking medicine:<sup>1</sup>

- Mix medicine with a small amount of food or drink, if appropriate. Crush tablets or open capsules in order to mix them. Let the child choose the food or drink. Always check with the health care provider, nurse, or pharmacist first to be sure this is OK.
- See if the pharmacist can change the form or flavor of the medicine to make it more palatable.
- Have the child take medicine at the same time the foster parent takes medicine or a vitamin. Have a contest to see who can take their medicine faster.

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<sup>1</sup> Adapted from *Caring for Children with Special Needs: For Parents, Foster Parents, and Other Caregivers Caring for Children with HIV* (NYS Department of Health and Office of Children & Family Services, September 2003), pp. 4-1–4-22.

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- A health care practitioner should demonstrate to caregivers the proper procedure for administering medication to babies.
- Don't ask the child whether he/she wants or will take the medicine. Be firm and say he/she needs to take it.
- Some children do best when they take a deep breath and drink the medicine down fast. Others take their medicine a sip at a time with a drink of juice in between. Sometimes it helps for the caregiver to count for the child while he/she takes the medicine.
- Offer a reward such as a sticker or star when the child takes the medicine.

### Administering/Taking Medication Outside the Foster Home

Whenever possible, dosing schedules should be planned to minimize the administration of medication outside the foster care setting. The use of long-acting formulations may eliminate the need to take medicine during the school day. However, there will still be times when children in foster care need to take medication while in school, on trips, or on home visits.

#### Medication in School

Foster parents must communicate with the school if children are routinely expected to take medications (e.g., Ritalin, Ventolin inhaler); schools will have their own procedures regarding medications.

It is recommended that you assist foster parents in making the initial contact with school health staff (often a nurse) to make the necessary arrangements for administering medication. Advise foster parents to bring the medication to the school in its original packaging as dispensed from the pharmacist. It may be necessary for the pharmacist to order an additional prescription to bring to school, or the pharmacy may provide an extra vial with a label.

#### Medication on Trips, Home Visits, and While Transporting

When foster parents take children on short trips, they should try to give the medication before or after the trip, if possible.

Depending on the home situation, caseworkers and/or foster parents should discuss the child's need for medication with birth parents when children are on home visits. The birth parents should be given the same amount of information and education regarding their child's medication as the foster parents. This supports the goal of involving parents in their child's overall health and well-being and will ease the eventual move from foster care back to the home.

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Agency policies must address information sharing procedures for birth parents. When children go on home visits, the parents should at least be advised about:

- The medication used, its purpose, and possible side effects.
- Importance of giving medication at its prescribed time and amount.
- Importance of safe storage of the medication.
- Family's role in administering medications to their child.
- Return of medications to the foster home or facility after each visit home.

For children in congregate care, staff supervising the home visit should consult the agency's policy on transporting the medication, administering it while on the home visit, storing any unused medication when returning to the facility, and documenting that the medication was given. Agency policy should address how the medication is transported (e.g., in its original pharmacy container, with a supply of cups and water jugs or juice bottles). Further, if extended home visits are part of the child's treatment, the agency's policy should address the activities listed above with the birth parents.

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# 7 Storage, Inventory, and Disposal of Medication

## Storage and Inventory

Regarding storage of medications, foster parents should follow these guidelines:

- Certain medications require refrigeration; if this is the case there will be a Keep Refrigerated label on the container.
- A cool, dry, dark cupboard is the best storage for most medications; remember that a bathroom medicine cupboard often becomes hot and steamy and is not the best place to store medications.
- Keep medications in a safe place and away from the reach or sight of small children.
- Always keep medication in the container in which it was received from the pharmacist. Do *not* remove the label until all the medication is finished. The information on the label is necessary to properly identify the patient, provider, medication, instructions for use, and date the prescription was dispensed.<sup>2</sup>

For children in congregate care, review your agency's procedures on medication storage and inventory. Ideally, a defined area should be designated for storage, preparation, and inventory of medication. These areas should be clean, well lit, and located so that staff are not interrupted when handling medication. Procedures should address the following points:

- Storing medication in a safe, locked, sanitary storage area, with controlled substances kept under double-locked storage.
- Controls on temperature and sanitation.
- Proper labeling.
- Access by authorized staff (i.e., keys or combinations).
- Location and access to First Aid Kits.
- Inventory control.
- Remember, nurses cannot dispense prescription medication from stock. Except for emergency and starter doses, all prescription medication must be administered from a package that was dispensed by a pharmacy for each specific child.

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<sup>2</sup> *New York State Foster Parent Manual* (Office of Children & Family Services, January, 2007), p. 33.

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### Disposal

It is important that old, outdated, and potentially dangerous medications *not* be kept available for use. Caregivers should flush down the toilet any remaining portion of a child's medication if the health care provider has discontinued the prescription.

In congregate care facilities, it is recommended that staff supervising medication administration should *not* discard medication. They should notify the health staff or the facility director/designee when a medication needs to be discarded.

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### 8 Psychiatric Medication

Medication can be an integral part of a comprehensive mental health treatment plan. The plan may involve various therapies and behavioral interventions as well as medication. Medication should not be the only treatment; in some instances, a child may need to be stabilized on medication before he/she is able to participate in therapy, but the child should begin therapy as soon as clinically able.

Many different kinds of mental health symptoms respond to psychiatric medications. Psychiatric medications, also called psychotropic, psychoactive, or behavioral medications, are chemical substances that act primarily upon the central nervous system where they alter brain function, resulting in temporary changes in perception, mood, consciousness, and/or behavior. Note that some medications may be used either as psychiatric medication or for another purpose; for example, Depakote (devalproex sodium) may be used as a psychiatric medication or as an anti-seizure medication; Catapres (clonidine) may be used to treat attention deficit hyperactivity disorder (ADHD) and tic disorders or to treat high blood pressure.

Children in foster care may be treated with psychiatric medication for conditions such as ADHD, attention deficit disorder (ADD), anxiety disorder, depression and other mood disorders, post-traumatic stress disorder, psychosis, tic disorders, and Tourette's syndrome, among others, as defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*.<sup>3</sup>

Because of the serious nature of psychiatric medication, agencies need to make sure that all children taking these medications are carefully monitored; receive initial and ongoing psychological or developmental assessments; and participate in all behavioral and mental health therapies identified in the treatment plan.



#### Health Care Coordination Activities

Assist caregivers in receiving appropriate training so that they will know how to give these medications safely and effectively. Monitor the recommended time intervals for physical and mental health examinations and make sure appointments are made and kept according to those time frames.

Review with the caregiver the possible side effects of psychiatric medications. They should know that each medication has its own specific side effects. Some medication causes drowsiness (driving a car or riding a bicycle can be dangerous); some medication has the opposite of the intended effect (e.g., anti-anxiety medication may cause excitement, sleeplessness, or irritability in some children). Especially if the child is on multiple medications, the caregiver should be alert to alarming changes in behavior, mood, or physical condition. As with any adverse side effects, caregivers should call the prescribing physician and contact the agency staff coordinating the child's health care. Recommended steps to take before starting a foster child on psychiatric medication include:

<sup>3</sup> American Psychiatric Association, Arlington, VA, 2000.

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- If the child is already taking psychiatric medication upon entry into foster care, contact the prescriber to verify the medication and obtain history.
- Obtain comprehensive physical and mental health assessments, including necessary lab work (*see Chapter One, section 3, Comprehensive Health Evaluation, for contents of assessments*). Diagnostic tests and symptom inventories and scales are recommended to provide a baseline of the child's health, mood, and functional status.
- The psychiatrist or physician formulates a diagnosis and/or identifies symptoms that would benefit from treatment with psychiatric medications. In some agencies, policy specifies that only a qualified psychiatrist can prescribe psychiatric medication.
- Child's treatment team meets to discuss the assessment findings and clinician's recommendations regarding psychiatric medications. Address the benefits and risks of medication, alternatives, and how medication is incorporated into the overall treatment plan.
- Provide parent/guardian with information on the proposed medication regimen and rationale; obtain informed consent (*see Chapter Six, Medical Consents*).
- Provide information to the child in a developmentally appropriate manner on the proposed medication regimen and how the child will be affected; obtain child's assent.
- Discuss with caregivers the reasons for prescribing medication; type, dosage, and date of medication prescribed; expected results and potential side effects of the medication; and instructions on administering the medication.

## Medication Monitoring

All children on psychiatric medication require careful and conscientious monitoring by the prescribing clinician. The monitoring schedule will vary, depending on factors such as the manufacturer's recommendations, how long the child has been on the medication, whether the dosage has stabilized, side effects, and the interplay between the effects of the medication and the rest of the mental health treatment plan. If your agency has specific requirements for the frequency of psychiatric medication monitoring, these must be communicated to the prescriber, the caregivers, the treatment team, and the child to support compliance.

Regular visits to the prescribing physician or psychiatrist include the following activities:

- Laboratory monitoring to assess the physical effects of the medication on the body. Testing may be quite frequent while dosages are being adjusted. Typical tests include:
  - Checking the level of drug in the system
  - White and red blood cell counts
  - Biochemical monitoring (e.g., liver function, cholesterol, and triglyceride levels)
  - EKG to assess cardiac conduction

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- Clinical monitoring to assess side effects or excess drug effects, which may include:
  - Weight gain or loss
  - Nausea
  - Hyperactivity
  - Confusion
  - Inability to focus attention
  - Drowsiness
  - Dizziness upon standing
  - Sleep problems
  - Blurred vision
  - Abnormal lactation
  - Abnormal movements (e.g., peculiar walk). The clinician may use an AIMS (Abnormal Involuntary Movement Scale) instrument to measure involuntary movements in the face, extremities, and trunk that are unique side effects of these medications (*see section 10, Resources, for a sample AIMS form*).
  
- Effectiveness of medication therapy. Agency protocols should address information sharing between the child’s psychiatrist and the therapist, teachers, caregivers, parent/guardian, and staff. An information gathering process is especially critical in congregate settings.
  - Repeat diagnostic tests and symptom inventories and scales to measure the impact of medication on the targeted symptoms.
  - Reports from the child’s therapist.
  - Information from the child’s caregiver, teacher, caseworker, and other people who are familiar with the child’s functioning.
  - Caregivers may participate in part of the child’s appointment to provide information.
  
- Periodic re-evaluations of the child’s mental health treatment plan, including the use of psychiatric medication, at the child’s periodic health visits and in Service Plan Reviews, with the prescribing physician present, if possible.

**Note:** More frequent contact will be required if the child is experiencing acute symptoms, receives high dosages of psychiatric medication, is on multiple medications, or requires emergency medication. It is recommended that children receiving long-term medication for a psychiatric reason have a comprehensive mental health reassessment at least once a year.

The Informational Letter, 08-OCFS-INF-02 The Use of Psychiatric Medications for Children and Youth in Placement; Authority to Consent to Medical Care (*see Appendix B*), provides extensive, additional guidance on the safe use of psychiatric medications for children in foster care. Review this Letter for further information on the appropriate use of these medications and monitoring and oversight activities. This INF is available at <http://www.ocfs.state.ny.us/main/policies/external/>.

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### Consent for Psychiatric Medication

The prescription of each psychiatric medication requires informed consent (*see Chapter 6, Medical Consents*). Informed consent means that the person giving consent has been informed of:

- Diagnosis and symptoms being treated.
- Nature of the medication: benefits, risks, and side effects.
- Projected course and duration of therapy.
- Alternative approaches to treatment.
- Assurance of monitoring.
- How to contact the prescribing psychiatrist/physician.
- How the medication fits with the treatment plan.

Prior written consent should be requested from a parent/guardian. The assent of the youth should also be sought as best practice, in accordance with his or her developmental level. See Chapter 6, Medical Consents, for detailed information on routine and informed consent for children under 18 in foster care.

Because of the impact of psychiatric medication, the important role of the parent or guardian must be recognized. Best practice is that staff make reasonable efforts to reach birth parents or guardians to obtain their consent, including telephoning, making a home visit, and sending a mailgram. Make sure that the parent/guardian understands the diagnosis and treatment, as well as the benefits and possible risks of the proposed medication. If parent/guardian refuses to give consent, give them the opportunity to meet the prescribing psychiatrist and get a second opinion, if they wish. Pursue any reasonable treatment options that the parent or guardian suggests.

A child 16 years of age or older residing in a hospital may consent to medically necessary psychiatric medication if the child has capacity to consent and the parent/guardian refuses to consent, or requiring their consent could have a detrimental effect on the child.<sup>4</sup>

To coordinate information on psychiatric medications, make sure that the consent form is completed, signed, and sent to the mental health provider (e.g., prescribing psychiatrist), with a copy included in the child's medical record (*see Appendix A for sample Informed Consent forms*).

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<sup>4</sup> MHL Title E, Article 33, 33.21.

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### Documentation

The medical record must contain the following:

- The maintenance dose of prescribed medication.
- The child's reaction to the medication.
- Information on medications that were discontinued and the reasons for discontinuance.
- Routine medication monitoring appointments with the prescribing psychiatrist.
- Ongoing appropriate lab work specific for the prescribed medication.
- A signed consent form.

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### 9 Controlled Substances and Congregate Care

Controlled substances are medications that have a high potential for abuse and addiction and are therefore subject to special laws and regulations governing prescription, storage, disposal, and record keeping. Some controlled substances are used as psychiatric medications (e.g., Ritalin), but many are used for other purposes (e.g., acetaminophen and codeine are used together to alleviate pain).

Controlled substances are classified into five groups or "schedules" (ranging from Schedule 1 with the highest potential for abuse to Schedule 5 with the lowest potential for abuse) based on:

- Their relative potential for abuse.
- Whether they have an accepted medical use.
- The degree of dependence that may be caused by abuse of the drug.

Substances within each schedule are also divided into narcotic and non-narcotic categories. The number and identity of substances that are controlled change periodically (*see section 10, Resources*). Article 33 of New York State Public Health law provides for standards related to the prescribing, dispensing, administration, storage, and inventory of controlled substances. Congregate care facilities must be licensed (class 3a) as "institutional dispensers, limited" by the New York State Department of Health to administer controlled substances to patients in accordance with a written prescription issued by an authorized physician or other authorized practitioner and filled by a registered pharmacy. To obtain an application for a license, contact the regional office of the NYS DOH's Bureau of Controlled Substances for your facility's region.

A prescription for a controlled substance is limited to a 30-day supply and may only be refilled with a new prescription. A practitioner may, however, issue a prescription for up to a three-month supply of a controlled substance if the prescription has been issued for the treatment of certain conditions (e.g., attention deficit disorder).<sup>5</sup>

**Note:** Controlled substances cannot be mailed. When foster parents go on vacation with a child taking a controlled substance, they should know that a pharmacy cannot mail the medication if needed. Foster parents will need to renew the prescription every 30 days.

Every facility must keep a continuous record ("perpetual inventory") for each controlled substance kept on the premises. All controlled substances must be stored in a double-locked cabinet, and the amount of each drug documented at the beginning and end of each shift. Staff certified to administer medications must perform and document the count of the remaining drugs at each shift change. To facilitate the count and reduce handling of prescriptions for controlled substances, ask your pharmacist to dispense unit dose blister packs (a package holding pills in a clear plastic case sealed to a sheet of cardboard, which allows for the dispensing of one pill at a time). In addition, the administration of the medication must be documented in the child-specific Medication Administration Record.

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<sup>5</sup> 10 NYCRR 80.67 (d)(1)(2)(3).

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### 10 Resources

#### Medication Information

Medline Plus is a service of the U.S. National Library of Medicine and the National Institutes of Health: <http://medlineplus.gov/>. Information is provided for drugs, herbs, and supplements listed by brand and generic names.

The National Alliance on Mental Illness (NAMI) provides information on psychiatric medications on their website:

[http://www.nami.org/Template.cfm?Section=About\\_Medications&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=51&ContentID=34819](http://www.nami.org/Template.cfm?Section=About_Medications&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=51&ContentID=34819)

*Treatment of Children with Mental Disorders* is a June, 2008 publication of the Office of Mental Health. This is an excellent resource for birth parents and foster parents.

<http://www.omh.state.ny.us/omhweb/booklets/ChildrensBook.htm>

#### Controlled Substances

##### **DEA Controlled Substances – Schedules and Drug Codes**

<http://bfa.sdsu.edu/ehs/deasched.htm>

For information on the classification of specific drugs, go to:

<http://www.deadiversion.usdoj.gov/schedules/schedules.htm>

#### Poison Control Centers

##### **Central New York Poison Center**

750 East Adams Street  
Syracuse, NY 13210  
Emergency Phone: 800-222-1222

##### **Finger Lakes Regional Poison & Drug Information Center**

University of Rochester Medical Center  
601 Elmwood Avenue, Box 321  
Rochester, NY 14642  
Emergency Phone: 800-222-1222  
TDD/TTY: 585-273-3854 (TTY)

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### **Long Island Regional Poison and Drug Information Center**

Winthrop University Hospital  
259 First Street  
Mineola, NY 11501  
Emergency Phone: 800-222-1222  
TDD/TTY: 516-924-8811 (Suffolk); 516-747-3323 (Nassau)

### **New York City Poison Control Center**

NYC Bureau of Labs, 455 First Avenue, Room 123, Box 81  
New York, NY 10016  
Emergency Phone: 800-222-1222  
TDD/TTY: 212-689-9014 (TDD)

### **Western New York Poison Center**

Children's Hospital of Buffalo  
219 Bryant Street  
Buffalo, NY 14222  
Emergency Phone: 800-222-1222

## **Abnormal Involuntary Movement Scale (AIMS)**

The AIMS (Abnormal Involuntary Movement Scale) measures involuntary movements in the face, extremities, and trunk that are unique side effects of psychiatric medications. This instrument is used by clinicians for children who are taking these medicines.

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### ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

Public Health Service  
Alcohol, Drug Abuse, and Mental Health Administration  
National Institute of Mental Health

NAME: \_\_\_\_\_  
DATE: \_\_\_\_\_  
Prescribing Practitioner: \_\_\_\_\_

CODE: 0 = None  
1 = Minimal, may be extreme normal  
2 = Mild  
3 = Moderate  
4 = Severe

**INSTRUCTIONS:**  
**Complete Examination Procedure (attachment d.)**  
**before making ratings**

<b>MOVEMENT RATINGS:</b> Rate highest severity observed. Rate movements that occur upon activation one <u>less</u> than those observed spontaneously. Circle movement as well as code number that applies.		RATER	RATER	RATER	RATER
		Date	Date	Date	Date
<b>Facial and Oral Movements</b>	<b>1. Muscles of Facial Expression</b> e.g. movements of forehead, eyebrows periorbital area, cheeks, including frowning blinking, smiling, grimacing	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	<b>2. Lips and Perioral Area</b> e.g., puckering, pouting, smacking	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	<b>3. Jaw</b> e.g. biting, clenching, chewing, mouth opening, lateral movement	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	<b>4. Tongue</b> Rate only increases in movement both in and out of mouth. NOT inability to sustain movement. Darting in and out of mouth.	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
<b>Extremity Movements</b>	<b>5. Upper (arms, wrists,, hands, fingers)</b> Include choreic movements (i.e., rapid, objectively purposeless, irregular, spontaneous) athetoid movements (i.e., slow, irregular, complex, serpentine). DO NOT INCLUDE TREMOR (i.e., repetitive, regular, rhythmic)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	<b>6. Lower (legs, knees, ankles, toes)</b> e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
<b>Trunk Movements</b>	<b>7. Neck, shoulders, hips</b> e.g., rocking, twisting, squirming, pelvic gyrations	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
<b>Global Judgments</b>	<b>8. Severity of abnormal movements overall</b>	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	<b>9. Incapacitation due to abnormal movements</b>	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	<b>10. Patient's awareness of abnormal movements.</b> Rate only patient's report No awareness 0 Aware, no distress 1 Aware, mild distress 2 Aware, moderate distress 3 Aware, severe distress 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
<b>Dental Status</b>	<b>11. Current problems with teeth and/or dentures</b>	No Yes	No Yes	No Yes	No Yes
	<b>12. Are dentures usually worn?</b>	No Yes	No Yes	No Yes	No Yes
	<b>13. Edentia?</b>	No Yes	No Yes	No Yes	No Yes
	<b>14. Do movements disappear in sleep?</b>	No Yes	No Yes	No Yes	No Yes

Final: 9/2000

# Working Together

## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

*NYS Office of Children and Family Services*

### *Chapter Six*

## Medical Consents

Consent is generally required to release medical and mental health records, provide treatment, and for a number of other situations such as prescribing psychiatric medication and testing for HIV. Giving medical consent is agreeing to and understanding the risks and benefits of the services to be provided. Because of their circumstances – being placed outside the home, possibly moving from one placement to another, having agency staff as well as health care providers involved with their care – children in foster care need special oversight and consideration regarding medical consent. As a result, the law generally requires that consent from the parent or guardian be obtained and documented for key medical activities and conditions.

This chapter covers the issues of consent as related to medical and mental health records, information, and treatment for children in foster care.



Sections in this chapter include:

1. Consent to obtain health records
2. Consent/authorization for routine evaluation and treatment
3. Informed consent for non-routine health care
4. Consent and Early Intervention Program
5. Minors' capacity to consent for specific health services
6. Consent and HIV/AIDS
7. Resources

# *Working Together*

## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### Medical Consent

The term “medical consent” in this chapter refers to several kinds of consent:

1. Consent for release of prior health records.
2. Consent/authorization for routine evaluation and treatment.
3. Informed consent for non-routine health care.



#### Health Care Coordination Activities

Make reasonable efforts to obtain consent from the birth parent or guardian to involve them in the health care needs of their child. Even if the birth parent or guardian signs medical consent forms, it is important to continue engaging them in their child’s ongoing medical/mental health treatment.

All signed consent forms must be placed in the child’s health file with other items on the child’s health history.

# Working Together

## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### 1 Consent to Obtain Health Records

Consent is required to obtain a foster child's health records.<sup>1</sup> The earlier the attempt is made to obtain the child's medical history, the better. Preferably, before placement or within 24 hours of placement, try to obtain the parent's or guardian's signature on the agency's consent for release of information form as part of the overall early engagement of the family.



#### Health Care Coordination Activities

Health care coordination activities to obtain the child's health records include:

- Diligent efforts to obtain records of any previous medical, mental health, or dental treatment.
- No later than 10 days after placement (emergency or Article 10 court-ordered), or before accepting a child into care (voluntary placement), asking the birth parent or guardian for written consent to release the child's past health records.<sup>2</sup>
- When consent cannot be obtained from the birth parent/guardian, obtaining the local social services commissioner's consent to release the records or a court order if appropriate.<sup>3</sup>
- Sending written requests with the appropriate consent to known medical providers who have treated the child for the child's treatment history and records.
- For any preschool child, making diligent efforts to obtain the child's birth record from the hospital where the child was born or from another hospital in possession of the record.

#### Consent for Family Health History

In addition to the child's health history, efforts should be made to learn the health status of birth family members, as this information will be helpful for the child. It is preferable to obtain documentation from the family member's medical provider to verify any condition reported. The person to whom the record pertains must give written consent for the medical provider to release records to you.

There is no prescribed time frame for requesting consent to obtain the family's health records, nor are family members compelled to consent to release of their records, though the assistance of the court

<sup>1</sup> 18 NYCRR 441.22(e); 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

<sup>2</sup> 18 NYCRR 441.22(e).

<sup>3</sup> Ibid.

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may be requested in serious circumstances. If you have received health information that you believe is credible and important for the child's medical provider to know, this information may be provided with the caveat that you are not able to verify it (*see Appendix A for a sample Health History Interview with Family form to assist in collecting this information*).

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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## 2 Consent/Authorization for Routine Evaluation and Treatment

Consent is required for routine evaluation and treatment of a child in foster care.<sup>4</sup> This includes consent for initial assessment, follow up and treatment, and ongoing periodic re-evaluation, as well as emergency medical or surgical care in the event that the parent or guardian cannot be located at the time such care becomes necessary. Authorization from the child's birth parent/guardian must be included in the child's health record. If authorization was not obtained from the birth parent/guardian, then consent from the local social services commissioner, authorized agency, or the court must be contained in the record.

The parent/guardian is not authorized to consent to medical care in the following two circumstances:

- When the LDSS has custody and guardianship through a surrender or termination of parental rights (child is freed for adoption), only the local commissioner may provide medical consent. If the child was surrendered directly to a voluntary authorized agency, only that agency may provide medical consent. Consents signed by the parent/guardian are no longer valid.
- A person who is 18 years of age or older, is married, or is the parent of a child may give consent to any medical care.<sup>5</sup> No one else is authorized to consent for care in this case unless the court has determined that the individual is incapacitated and appointed a guardian or has otherwise intervened to authorize medical care.



### Health Care Coordination Activities

Health care coordination activities regarding consent for routine evaluation and treatment include:

- Within 10 days of placement, requesting authorization from the birth parent or guardian for all assessments and treatments that are part of the initial comprehensive evaluation. This includes all routine medical and/or mental health assessments, immunizations, and ongoing routine health care.
- Within 10 days of placement, requesting authorization from the birth parent or guardian for emergency medical or surgical care. Your agency may have a specific form for this type of consent, or it may be included in the consent for routine evaluation and treatment form.

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<sup>4</sup> 18 NYCRR 441.22(d).

<sup>5</sup> PHL 2504.1.

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- When authorization cannot be obtained from the parent or guardian, obtaining authorization from the local social services commissioner or designee for a child placed pursuant to an emergency protective removal or Article 10 court order.

➔ Remember to give a copy of the signed consent form for routine evaluation and treatment to the child's primary care provider and any other providers treating the child. It is recommended that staff document any specific discussions about medical consent in the child's health record.

## Consent and Voluntary Placement

When a child is voluntarily placed in care, the caseworker may obtain the birth parent's consent for medical/mental health care at the time the Voluntary Placement Agreement is signed.

## When Consent Is Not Available

### Medical Emergency

➔ In a medical emergency, children in foster care should receive treatment even if a signed consent form is not available.<sup>6</sup>

Absence of written consent should not delay emergency or urgent health care.

### Legal Authority

When consent is not available, the worker's actions depend on the legal authority under which the child is placed in foster care.

- When the child is placed as a result of an Article 10 court order or emergency protective removal, and there is no signed consent in the child's health record, seek consent from the local commissioner or designee.<sup>7</sup>
- When the child is placed voluntarily or as a result of an Article 7 (PINS) court order, only the birth parent or guardian can give consent to obtain health records and for routine evaluation and treatment. Neither the local commissioner nor the voluntary agency has authority to consent to medical care, so a court order must be sought.

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<sup>6</sup> PHL 2504.4.

<sup>7</sup> SSL Article 6, Title 1, 383-b.

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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- Children may be placed under Article 3 (JD) with a LDSS or with OCFS:
  - When a child is placed with a LDSS commissioner and the parent/guardian does not consent to routine care, a court order must be sought.
  - When a child is placed with OCFS, OCFS has the authority to consent to routine medical care. Thus, if the child is adjudicated as a juvenile delinquent and placed with OCFS and OCFS then places the child with a voluntary authorized agency, OCFS has the authority to consent to routine medical care in the absence of the parent or guardian.

When a parent/guardian refuses to provide needed consent for treatment of a child, this may lead to an evaluation of whether the case should be referred to Child Protective Services (CPS) as a possible medical neglect case. This may be considered even when the situation is not life threatening but there is risk of serious harm if the child is not treated. Consult with an appropriate medical practitioner about the implications of the child not receiving medical care.

**Note:** Commissioners may delegate specific staff on an administrative level within the agency or in a contract agency to provide written consent on behalf of the commissioner in appropriate cases. Make sure that you know who has this authority. Be familiar with the policies of your agency/local district regarding medical consent for each child under your care.

## Consent and Foster Parents

➔ **Foster parents, including kinship foster parents, are not authorized to give consent.** Instruct foster parents to contact the agency for consent if the consent form is not available (e.g., if a prescription for psychiatric medication changes or surgery is being planned). Agencies should establish protocols for giving health care providers a copy of the original signed consent form for their files. The only exception is when foster parents serve as surrogate parents for children in the Early Intervention Program, described in section 4 of this chapter. Then the foster parent can consent to Early Intervention services.

Communicate to foster parents the following information:

1. As a foster parent, you cannot provide consent for medical or mental health treatment. Keep a copy of the signed consent forms with you.
2. If a signed consent form is not in the health care provider's file, and the child needs routine treatment, the provider should contact the agency for consent.
3. In an emergency, the health care provider or emergency room may treat the child even if consent is missing, but they should seek consent from the agency as soon as possible. Have the agency phone number with you at all times.

# *Working Together*

## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### Consent and Relatives

There are different circumstances under which children involved with family court may come to reside with relatives. In these cases, it is recommended that agency staff explain consent and guardianship to the child's health care provider(s).

- The relative may be certified as a kinship foster home for a specific child. The child is in foster care. The relative is not authorized to consent to medical care (see above)
- The relative or another person who is not the parent of the child has a lawful order of custody of the child. The child is not in foster care. The relative cannot consent to medical care unless authorized by court order or designated in writing as a person in parental relationship to the child. The relative does have the right to enroll the child in school and enroll the child in their employer-based health insurance plan.<sup>8</sup>
- The relative or another person who is not the parent of the child has been granted legal guardianship or "permanent guardianship." The child is not in foster care. The relative may give medical consent for the child.<sup>9</sup>

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<sup>8</sup> Family Court Act §657. Effective 11/3/08.

<sup>9</sup> Family Court Act §661(b). Effective 11/3/08.

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### 3 Informed Consent for Non-Routine Health Care

Even if consent for routine evaluation and treatment has been obtained, medical providers will generally look for a higher level of consent – known as “informed consent” – for non-routine or elective medical or mental health care not generally provided as part of primary health care. Local districts that have obtained consents from a parent or guardian should evaluate the scope of such consent to determine whether it addresses both routine and non-routine medical care and treatment. For procedures or interventions that are not emergency in nature but call for informed consent, the health care provider should always contact the caseworker or the health care coordination staff at the agency. It is then the agency’s responsibility to facilitate the consent process.

Informed consent is required for:

- Any hospitalization.
- Dispensing of any psychiatric medication (*see Chapter 5, Medication Administration and Management*).
- Any procedure that requires anesthesia.
- Any surgery.
- Any invasive diagnostic procedure or treatment.

“Informed consent” implies that the person giving consent has had the opportunity to ask questions, understands the risks, benefits, and alternatives of the treatment, and has been informed of the following types of information:

- Diagnosis and symptoms being treated.
- How the procedure/therapy fits with the treatment plan.
- Nature of the procedure/treatment.
- Benefits, risks, and side effects.
- Projected course and duration of therapy.
- Alternative approaches to treatment.
- Assurance of monitoring for complications and side effects.
- How to contact the clinical provider of the proposed procedure/treatment.
- Location where the procedure/treatment will be performed.
- Necessity, type, and risks of anesthesia, if any.
- Proposed length of hospitalization, if any.

It is best to give this type of information to the person who will provide consent orally (in their native language) and to be available to answer questions. If requested, follow up the discussion with information in writing. If the informed consent is for psychiatric medication, written information on the medication should always be provided.

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### Authority to Provide Informed Consent

As with consent for routine care, the authority to provide informed consent is dependent upon the legal authority under which the child was placed in foster care. The parent/guardian should be asked to provide informed consent unless parental rights have been surrendered or terminated, or the child is 18 or older, married, or the parent of a child.

If the birth parent or guardian objects to signing the consent, take the following steps:

- Work with them to understand the basis of the objection.
- Pursue any reasonable treatment options that the parent may suggest.
- Provide the parent or guardian an opportunity to meet with the practitioner and treatment team.
- Assist the parent or guardian in obtaining a second opinion, if requested.

### If Parent/Guardian Does Not Give Consent for Psychiatric Medication<sup>10</sup>

If the parent or guardian and the treatment team cannot agree on the use of psychiatric medication, the local district or authorized agency may wish to seek legal counsel to determine if court intervention is advisable.

If the parent or guardian is *unavailable* or the parent or guardian *does not respond* to repeated requests to provide informed consent, consent may be provided in accordance with the legal placement authority.

- If the child is placed pursuant to an order or adjudication under Article 10 (child protective) of the Family Court Act (FCA), the social services commissioner or his or her designee can provide consent.
- If the child is placed voluntarily or pursuant to FCA Article 7 (PINS), a court order must be sought to authorize the medication.
- If a youth is placed pursuant to FCA Article 3 (juvenile delinquent) in the custody of a local social services district, a court order must be sought to authorize the medication.
- If the youth is placed pursuant to FCA Article 3 in the custody of OCFS and psychiatric medications were part of an existing health care plan at the time the youth was admitted to OCFS custody, the placement order authorizes OCFS to continue the existing course of treatment without additional consent. The introduction of new psychiatric medications would require a court order.

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<sup>10</sup> For more information, see: 08-OCFS-INF-02 The Use of Psychiatric Medications for Children and Youth in Placement; Authority to Consent to Medical Care. [http://ocfs.state.nyenet/policies/external/ocfs\\_2008/infs/08](http://ocfs.state.nyenet/policies/external/ocfs_2008/infs/08)

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- If a child is placed pursuant to a surrender or termination of parental rights, the social services commissioner or authorized agency with guardianship of the child provides consent. Parental consent is not sought.

The commissioner or designee and the court if applicable must also receive information on the medication in order to provide an informed consent (*see Appendix A for sample forms*).

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### 4 Consent and Early Intervention Program

The Early Intervention (EI) Program requires the appointment of a “surrogate parent” to assume the responsibilities of a birth parent/guardian when a child in foster care is eligible for Early Intervention Services and is either a ward of the state – i.e., in the custody and guardianship of the local commissioner of social services – or is not a ward of the state but whose birth parent/guardian is unavailable. The Early Intervention Official/Designee (EIO/D) should designate the foster parent or an appropriate and available relative as the surrogate parent for the EI Program (*see Appendix D for the Protocol: Children in Foster Care Who Participate in the Early Intervention Program, pages 10-12, for information on appointing a surrogate parent*).

The role of the surrogate parent is to make decisions regarding the child within the Early Intervention system. The surrogate parent is afforded the same rights and responsibilities as afforded to the parent and represents the child in all matters related to: screening, evaluation, Individualized Family Service Plan (IFSP) development and implementation, provision of early intervention services, periodic review of IFSP services, and due process procedures. A surrogate parent has access to all Early Intervention Program records concerning the child and due process rights related to those records.

When a child is in foster care and a referral has been made to the EI Program, the EIO/D should consult with the social services district to determine whether parental rights have been terminated or voluntarily surrendered, and whether the parent is available. This also provides an opportunity to share information; identify any potential barrier to parental consent and participation; and determine the need for and identify, as appropriate, a suitable surrogate parent.

A surrogate parent and a birth parent/guardian are not mutually exclusive, and a child can have both. Unless parental rights have been terminated, the EI Program and foster care systems should take steps to encourage the birth parent/guardian to be involved in the IFSP process and in Early Intervention services even when a surrogate parent has been appointed.

Under the Individuals with Disabilities Education Act (IDEA), the surrogate parent may *not* be an employee of any state agency (LDSS commissioner, caseworker, case manager, case planner) or a person or employee of a person providing Early Intervention services (EIO/D, EI Service Coordinator) to the child. The IDEA specifically excludes state officials from acting as a surrogate parent in the EI Program.

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### 5 Minors' Capacity to Consent for Specific Health Services

Minors (persons under the age of 18) may give consent to obtain past health records and to receive specific health services if it has been determined that they have the “capacity to consent.” Capacity to consent means “an individual’s ability, determined without regard to the individual’s age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure; or of a proposed disclosure of confidential HIV-related information, as the case may be, and to make an informed decision about the service, treatment, procedure, or disclosure.”<sup>11</sup> Capacity to consent is defined by the health care practitioner who is providing the treatment.

This means that a minor with capacity to consent can make choices regarding testing and treatment for the health services listed below without consulting a parent or other responsible adult. Although a minor with capacity to consent may consent for the specific health services listed below, health care providers and agency staff may wish to encourage the youth to talk over the situation with a parent or supportive adult. Even a minor who understands the risks and benefits and can make the decision alone may benefit from support and discussion with a trusted adult.

#### Reproductive Health Services/Family Planning Services

Minors may give consent to receive reproductive health services and family planning services.<sup>12</sup> This includes gynecological exams, pap tests, contraceptives (including emergency contraceptives), pregnancy testing, pregnancy options counseling, counseling on sexual decision-making, and treatment for vaginal infections. Pregnant teens may give consent to medical, dental, health, and hospital services related to prenatal care.

Minors may consent to their own testing and treatment for sexually transmitted diseases (STDs).<sup>13</sup>

Minors may consent to their own pregnancy termination.<sup>14</sup> The youth has no obligation to report the pregnancy or the termination to the agency, birth parent/guardian, or foster parent.

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<sup>11</sup> PHL Article 27-F; 18 NYCRR 441.22(b)(1).

<sup>12</sup> 431 U.S. 678; 1977 U.S. Supreme Court decision in *Carey vs. Population Services International*.

<sup>13</sup> PHL Article 23, 2305(2).

<sup>14</sup> PHL Article 25, 2504.

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### Consent and Teen Parents

- Any person who is the parent of a child may give effective consent for medical, dental, health, and hospital services for herself or himself, and the consent of no other person is necessary.<sup>15</sup>
- If a teen parent is in foster care and has custody of her child who is not in foster care, the teen may give consent for health care for herself and her child.<sup>16</sup>
- If the teen parent and her child are both in foster care together, the teen may give consent for health care for herself and her child.
- If the teen parent and her child are both in foster care, but the child lives elsewhere because of an Article 10 removal, the local social services commissioner can give consent if the teen parent refuses.

It is recommended that staff explain these situations and related consent issues with health care providers.

### Outpatient Mental Health Services

Mental health services are considered part of routine health care, and consent is provided pursuant to the parent/guardian's authorization obtained when the child enters care. Parental consent is required, except as noted below.<sup>17</sup>

Minors may consent to outpatient mental health services if the youth knowingly and voluntarily seeks the services, the services are deemed necessary to the youth's well-being, and (1) the parent/guardian has refused consent; (2) the parent/guardian is not reasonably available to consent; or (3) requiring consent of the parent could have a detrimental effect on the treatment.<sup>18</sup>

### Inpatient Psychiatric Services

Youth 16 or older residing in a hospital may consent to medically necessary psychiatric medications if (1) the parent/guardian is not reasonably available to consent; (2) the parent/guardian refuses consent (and a second medical opinion confirms the capacity of the youth to consent and necessity of medication); or (3) requiring consent of the parent could have a detrimental effect on the minor (and a second medical opinion confirms possible detrimental effect, capacity of the youth to consent, and necessity of medications).<sup>19</sup>

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<sup>15</sup> PHL 2504.1.

<sup>16</sup> PHL 2504.

<sup>17</sup> MHL 33.21.

<sup>18</sup> Ibid.

<sup>19</sup> Ibid.

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A patient who is a minor may be provided treatment over his or her objection if the patient's parent, legal guardian, or other legally authorized representative has consented to the treatment, and the treatment is not one for which the consent of a minor would be legally sufficient. An independent review process is required if the minor is a patient in a State-operated psychiatric center and objects to psychiatric medication.<sup>20</sup>

In regard to the right to object, a patient under the age of 18 in a hospital or secure treatment facility operated by the Office of Mental Health is considered an adult rather than a minor if that person is married, the parent of a child, or has made a voluntary application for admission.<sup>21</sup>

### Chemical Dependency Services

Chemical dependency services are considered part of routine health care, and consent is provided pursuant to the parent/guardian's authorization obtained when the child enters care. Parental consent is required, except as noted below.<sup>22</sup>

Minors may consent to alcohol abuse and substance abuse services if treatment is deemed necessary for the child's best interests, and (1) the parent/guardian has refused consent; (2) the parent/guardian is not reasonably available; or (3) requiring consent of the parent could have a detrimental effect on the course of treatment.<sup>23</sup> This includes alcohol abuse and substance abuse services provided on an inpatient, residential, or outpatient treatment basis.

Admission to chemical dependence residential rehabilitation services for youth is voluntary. A patient is free to discharge himself or herself from the service provider at any time.<sup>24</sup>

### Blood Donations

Any person age 17 or over can consent to donate blood in any voluntary and noncompensatory blood program.<sup>25</sup>

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<sup>20</sup> 14 NYCRR 527.8(c)(2).

<sup>21</sup> 14 NYCRR 527.8(a)(5).

<sup>22</sup> MHL 22.11.

<sup>23</sup> MHL 22.11.

<sup>24</sup> 14 NYCRR 817.3(k).

<sup>25</sup> PHL Article 31, 3123.

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### 6 Consent and HIV/AIDS<sup>26</sup>

Considering the extent of the HIV/AIDS epidemic and the lack of vaccine or cure for the disease, agencies must take preventive measures including risk assessment, counseling, and testing, and arrange for medical care when needed. As noted in Chapter 1, Initial Evaluation of Child's Health, all children entering foster care must be assessed for risk of HIV. Who can give consent for HIV risk assessment and testing and how consent is obtained are important issues. The agency must have protocols as to who is the local commissioner's designee in this matter and a consent document that addresses HIV to present to the health care provider. General consent forms do not address consent for an HIV test. (See Chapter 7, Confidentiality of Health Information, for information on HIV testing and confidentiality).

It is recommended that designated staff who are informed about HIV, foster care, and developmental stages make the determination as to whether a child has the capacity to consent. Designated staff may include health staff, social work staff, and medical providers.

Children in foster care may consent for HIV testing and family planning procedures if it has been determined that they have the capacity to consent. → **No one other than the child can consent to an HIV test if the child has the capacity to consent.**

#### Initial HIV Risk Assessment

Regarding the initial HIV risk assessment, first determine which alternative applies: (1) there is no possibility that the child has the capacity to consent; or (2) there may be a possibility that the child has the capacity to consent.

The following categories provide best practice guidelines for making the determination:

- Infants and preschool children clearly have no capacity to consent. Obtain consent from the parent or legal guardian, the designated representative on an administrative level, or by court order, and complete the initial risk assessment within five days of placement.
- Elementary school children generally will have no possibility of capacity to consent, particularly in the lower grades. Since there may be a possibility of such capacity in exceptional cases, complete the risk assessment and determine capacity to consent for HIV testing within 30 days of placement.

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<sup>26</sup> 18 NYCRR 441.22(b); 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure.

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- Middle school children are more likely to have the possibility of capacity to consent, but the broad range in individual development requires a case-by-case determination. It is recommended that a supervisor review the determination. Since there may be a possibility of such capacity, complete the risk assessment and determine capacity to consent for HIV testing within 30 days of placement.
- High school and post-high school youth will generally have the capacity to consent, although there may be exceptions in cases of developmental delay or disability and/or mental or emotional instability. In most cases, adolescents and young adults will be able to understand and appreciate the nature and consequences of the disease and make an informed decision regarding the recommended testing when risk is identified. Complete the risk assessment and determine capacity to consent for HIV testing within 30 days of placement.

## HIV Testing

When HIV risk has been identified, designated staff will need to obtain legal written consent before the child can be tested. The current DOH consent form should be used (*see section 7, Resources*). Caseworkers may never provide legal consent for HIV testing of a foster child. Inform foster parents and prospective adoptive parents that they may never provide legal consent for HIV testing of a foster child.

If a child or youth has been determined to have the capacity to consent, and agrees to be tested (after being identified as having one or more risk factors and counseled regarding testing and confidentiality), obtain his or her signature on a brief statement of consent.<sup>27</sup> A child with capacity to consent is the only person who can make the decision about testing and consent to the test. The child will also have to sign a consent form at the test site.

If it has been determined that a child does *not* have the capacity to consent, staff follow a different process depending on how the child was placed in foster care:

- For a child placed by emergency protective removal or by an Article 10 court order, ask the parent/guardian for permission to test the child for HIV and request a written response within 10 days. If the parent agrees to give consent for the test in writing and is able to be present at the test site with the child, schedule the appointment and make arrangements for the test, including transportation, if necessary. If the parent refuses or is unable to provide written permission for testing a child identified as being at risk, and you have made reasonable efforts to contact him or her and discuss the importance of the test, you will need to obtain the legal consent for testing from the local commissioner or designee.

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<sup>27</sup> This consent form is for the LDSS. At the testing site, the youth will be asked to sign the Department of Health's official informed consent form.

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- For a child placed voluntarily by the parent/guardian, or placed as a PINS or JD, written consent from the birth parent or guardian is required in order to test the child for HIV. If the parent/guardian refuses to provide consent, discuss the importance of early detection. If the parent continues to refuse, determine whether to ask for a court order based on urgent medical necessity.
- For children under 12 months of age at entry into care, request results of the Newborn Screening within 10 days of entry into care. Under New York State law, a sample of blood is taken from every newborn to test for several serious disorders. Since 1997, the Newborn Screening Program has included an HIV test. If the test is positive, that means the child has been exposed to the HIV virus. Seek medical care immediately. (*See Chapter 3, Special Health Care Services, section 2, HIV-Related Services, Newborn Screening Program.*)



### Health Care Coordination Activities

Whenever the local social services commissioner or designee is responsible for providing consent for HIV testing, health care coordination activities include obtaining the signed consent and making arrangements for the test.

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### 7 Resources

#### **New York Civil Liberties Union**

Go to <http://www.nyclu.org/>, select Resources – Know Your Rights. Information on reproductive rights is available.

#### HIV Consent

See Appendix A for the “Informed Consent to Perform an HIV Test” form (DOH-2556). For a copy of the form in English and other languages, go to the NYS Department of Health website, <http://www.health.state.ny.us/>, and click on HIV/AIDS.

See Appendix B for 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure. This ADM includes model forms for HIV consent.

#### Brochures on Consent

- *Medical Consent for Foster Children*
- *Consent for Psychotropic Medication*

Both brochures are available from the Office of Medical Services Planning, New York City Administration for Children’s Services (ACS), 150 William St., 14<sup>th</sup> Floor, New York, NY 10038.

- *Pediatric AIDS Unit (for consent related to HIV/AIDS)*

This brochure is available from the Pediatric AIDS Unit, New York City Administration for Children’s Services (ACS), 150 William St., 14-P1, New York, NY 10038.

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### Chapter Seven

## Confidentiality of Health Information

All medical and mental health information about a child in foster care must be kept confidential in accordance with section 372 of the Social Services Law. They may be shared only with health practitioners, health staff, caseworkers, direct care workers, and foster parents (with some exceptions) when they need it to provide adequate care and supervision. Confidentiality applies to names, addresses, and telephone numbers of children, foster families, and relatives as well as the child's health information.

Specifically, "Information to be safeguarded includes names and address of applicants (*for services*), 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."<sup>1</sup>

This chapter covers issues related to sharing health information and confidentiality of medical records and other health information.



Sections in this chapter include:

1. Sharing health information
2. Flow of confidential health information
3. Confidentiality and disclosure of HIV-related information
4. HIV testing and confidentiality
5. Agency protocols for protecting confidentiality
6. Resources

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<sup>1</sup> 18 NYCRR 357.1.

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### 1 Sharing Health Information

Caseworkers and health staff should share health information on children in foster care with others who need it to provide assessment, treatment, services, and care and supervision. This includes health care providers, health professionals, caregivers, and birth parents/guardians in most cases.

At the time of placement, the agency must provide the comprehensive health history of the child and his/her birth parents and the health care needs of the child to the foster parents.<sup>2</sup> Since foster parents play an important role in the ongoing health care and well-being of children in their care, they should be familiar with the child's medical history and records.

Most birth parents may have access to health information for their child in foster care. However, if the child is freed for adoption, do not share health information with the birth parent since parental rights have been surrendered or terminated. To the extent it is available, the agency must provide the comprehensive health history of the child and birth parents to prospective adoptive parents, and, upon request, to adoptive parents. Information identifying the birth parents must be removed when the records are provided.<sup>3</sup>

Exceptions to agency sharing of information include:

- Information related to reproductive health services, family planning, and STD testing and treatment; prenatal care and labor and delivery services (*see Chapter 6, Medical Consents*).

A foster child or youth with capacity to consent has the right to confidentiality regarding issues of family planning and reproduction, and sexually transmitted diseases.<sup>4</sup> This information may not be shared with caseworkers, health staff, the child's foster parent, or birth parent or guardian without the express consent of the child with capacity to consent. It is recommended that staff encourage the child with capacity to consent to share information with an adult who is responsible for his or her care.

- Information related to HIV/AIDS testing and treatment when the child has the capacity to consent (*see section 4, HIV Testing and Confidentiality*).
- Information related to chemical dependency (substance abuse) services. Service providers will require written consent from the youth before releasing information to the agency. Once received, the information cannot be redisclosed without consent of the youth.<sup>5</sup>

Other professionals such as CASA<sup>6</sup> workers may only have access to confidential health information for a child in foster care through court order. They may not have access to HIV-related information unless specifically authorized in the court order.

<sup>2</sup> 18 NYCRR 357.3(b)(2) and 441.22(j)(1).

<sup>3</sup> 18 NYCRR 357.3(b)(3).

<sup>4</sup> PHL 17.

<sup>5</sup> 42 CFR 2.14.

<sup>6</sup> Court-Appointed Special Advocates.

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Regarding internal sharing of information, locally established written procedures should facilitate sharing of medical or health-related information in the case record between LDSS foster care staff and the Medical Assistance and C/THP units of the agency. Such cooperative communication procedures are necessary to support the child's receipt of all required health services.

### CONNECTIONS

The CONNECTIONS Health Services Module has been designed to provide a systematic and organized presentation of the general health history and other critical health information pertinent to a child being served through the child welfare system. The primary purpose is to allow the child's case manager, case planner, assigned caseworker, agency nurse, or health care coordinator easy access to the most critical health information for the child. Maintaining the health module for each child in foster care is an efficient method for sharing this information.

If health information was obtained by the agency pursuant to authorized consent, no additional consent is required to enter this information into CONNECTIONS, except as noted in the next paragraph.

Confidential HIV-related information on anyone other than a foster child must not be entered into CONNECTIONS. The CONNECTIONS system does not have a built-in system capability to limit access to confidential HIV-related information to only those persons authorized by statute to have access. Therefore, the social services district or voluntary authorized agency must administer the system in a compliant manner. If a parent has HIV/AIDS, reference may be made in the case record to the parent's serious chronic illness without naming the diagnosis.

The health module has an enhanced level of security to protect the child's confidentiality. Details regarding the health module, including confidentiality examples, can be found in 08-OCFS-ADM-01.

### Transfer or Discharge

When a child moves from one placement to another, the child's comprehensive health history must be transferred to the new placing agency, if different, and a copy given to the new caregiver.<sup>7</sup> In congregate care, the entire, original health record must be immediately transferred with the youth to the next placement. The correct agency must be assigned health care responsibility in CONNECTIONS.

Upon discharge from foster care, a copy of the child's health records must be given to the discharge resource (birth parent, guardian, adoptive parent, or at no cost to the youth if discharged to independent living). Confidential HIV-related information must not be disclosed to the discharge resource without a written release from the child if the child has the capacity to consent."<sup>8</sup>

<sup>7</sup> 18 NYCRR 357.3(b)(1) and 441.22(m).

<sup>8</sup> 18 NYCRR 357.3(b)(5).

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➔ Encourage those receiving the records to share the child's health history with medical and mental health care providers if different from those treating the child while in care. For continuity of care, it is recommended that the child or youth continue to see the same health care providers as seen during placement, if possible.

### Youth's Access to Own Health Records

When a youth makes a written request for the opportunity to inspect information related to his or her treatment in the possession of a health care provider, the provider must provide access to the information within 10 days. If parental consent was required for the services, the parent should make the request to view health records.<sup>9</sup>

### Sharing Health Information in Congregate Care

In congregate care facilities, the health services staff are responsible for maintaining the confidentiality of health records. Access to health records is limited to health professional staff providing care to the youth or, in the absence of health staff, the agency director or designee, as well as the case manager, case planner, and caseworker assigned to that child. Certain other staff may be informed of a youth's health problems if that information is necessary for the staff to adequately perform their responsibility to provide for the health and safety of that youth. Health records should be secured in a locked cabinet, drawer, or room. Access to health information in CONNECTIONS should be granted based on the individual's need to know.

Regarding the release of records:

- Copies of relevant portions of the health record may be released to specialty health care providers (e.g., cardiologist) as needed in order to evaluate and treat the youth.
- Confidential information related to HIV infection may only be released following procedures defined in New York State Public Health Law Article 27-F and requires the written consent of the youth in most circumstances (*see Chapter 6, Medical Consents*).

**Note:** Your agency should have clear statements of policy and practice on gathering and sharing health information about children in placement and their families. It is recommended that agencies obtain legal guidance regarding their rights, responsibilities, and risks regarding sharing of health information.

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<sup>9</sup> PHL Article 1, Title 2, 18(2)(c).

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## 2 Flow of Confidential Health Information

When a child is placed in foster care, confidential health information should flow as follows:

- Birth parent/guardian provides past medical/mental health information and/or signs written release forms for prior health care providers to pass on this information.
- Agency staff sends request for release of prior health records form to prior health care providers.
- Prior health care providers send information to agency.
- Agency staff works with current health care providers and caregivers to obtain documentation of every health service provided while in foster care.
- Agency staff enters necessary information into CONNECTIONS.
- Agency staff shares information with caregivers and foster parent, as needed.
- Agency staff sends necessary information to specialty health care providers.
- Health information in CONNECTIONS populates sections of the Permanency Hearing Report. Review thoroughly before submitting to the court.
- Agency staff sends necessary information to discharge resource (birth parent, guardian, adoptive parent, child as appropriate) and same (or new) medical home.

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### 3 Confidentiality and Disclosure of HIV-Related Information

Because of the sensitive nature of HIV/AIDS, the law<sup>10</sup> has strict provisions about confidentiality and disclosure of HIV-related information. All person-specific HIV-related information, even the fact that someone has been HIV tested, must be maintained in a confidential manner.<sup>11</sup> HIV information on anyone other than a foster child should not be entered into the CONNECTIONS system.

“Confidential HIV-related information means any information in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV-related information concerning whether an individual has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify an individual as having one or more such conditions, including information pertaining to such individual’s contacts.”<sup>12</sup>

In all cases when HIV-related information is made available, a warning statement against further disclosure or redisclosure must be given to those receiving the information, except for those listed below in (d) (*see Section 6, Resources, for redisclosure statement*).

The HIV Risk Assessment protocol was established to benefit children in foster care through effective early identification, treatment, education, and risk reduction. The confidentiality requirements surrounding HIV should not interfere with the agency’s responsibilities to appropriately plan and provide services to the child. As the child’s assigned case manager, case planner, and caseworker are integral to these activities, these individuals have a need to know the HIV status of children on their workload. HIV information concerning a child in foster care may be shared *within* an authorized agency with staff who have a need to know without provision of a warning statement against redisclosure.

Requirements for confidentiality and disclosure of HIV-related information on children in foster care:

a. Direct access to HIV-related information concerning a foster child is limited to:

- The authorized agency responsible for the child.
- Staff within the authorized agency who need to know the information to supervise, administer, monitor, or provide services to the specific child and family.
- The child’s medical care provider/facility.

<sup>10</sup> PHL Article 27-F.

<sup>11</sup> 18 NYCRR 431.7; 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure.

<sup>12</sup> PHL Article 27-F, 2780(7).

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- The child with capacity to consent.
  - The person authorized to give consent, if the child lacks capacity to consent.
- b. The agency *must* disclose HIV-related information concerning a foster child, *whether or not the child has capacity to consent*, to the following:
- The child's foster parents or relative foster parents.
  - The child's adoptive or prospective adoptive parents.
  - Another authorized agency if the child is transferred.
  - The child's law guardian.
  - The child, if discharged into his/her own care.
  - A former foster child who has since been adopted, upon request.
- c. The agency *must* disclose HIV-related information concerning a foster child to the following *only under certain circumstances*:
- The parent/guardian if the child lacks capacity to consent.
  - The parent/guardian of a child with capacity to consent only if the child provides written consent to disclosure to the parent/guardian.
  - In a court hearing only when ordered by the judge after a hearing on the issue of disclosure.
  - Community service providers only when necessary to obtain essential health or social services for the foster child, and only when the local social services commissioner or designee has signed specific authorization for the disclosure. Examples of providers: psychologist, home aide, day care or school staff only when medication or other medical necessity directly related to HIV infection or AIDS is involved.
- d. The right of a person in (b) or (c) to redisclose confidential HIV-related information concerning a foster child is limited to the following:
- The child's adoptive parent or prospective adoptive parent of a foster child freed for adoption.
  - The child's foster parents or relative foster parents only when necessary for the care, treatment, or supervision of the child.
  - The child's law guardian when necessary to represent the child without capacity to consent in court proceedings.
  - The child's law guardian when necessary to represent the child with capacity to consent in court proceedings only if the child has provided written consent for such disclosure.

*(See Appendix A for the NYS DOH Authorization for Release of Confidential HIV-Related Information form.)*

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### 4 HIV Testing and Confidentiality

When a foster child has the capacity to consent, and HIV risk has been identified, the child or youth has the right to make all decisions about an HIV test, the type of test, and a *limited right* to make certain decisions about disclosure of information related to an HIV test. Part of the counseling of children with capacity to consent is informing them about these rights. The capacity to consent to the release of HIV-related information is determined without regard to the youth's age. Disclosure of HIV-related information requires written authorization, except as noted on the previous page.<sup>13</sup>

After being counseled about testing, the child or youth has the right to decide whether to have agency-supervised confidential HIV-related testing or the alternative of anonymous testing. Staff activities differ according to the decision:

- If the child or youth chooses confidential testing, obtain the child's written consent on DOH-2557 for redisclosure of test results to the agency, and arrange for testing within 30 days of the consent. Test results will be reported by the test site to the agency and recorded in the youth's health record, including the CONNECTIONS system.
- If the child chooses anonymous testing, offer to help the child obtain access to an anonymous testing site. The choice of anonymous testing is available in foster care only to a child or youth with capacity to consent. When anonymous testing is chosen, only the child or youth will receive the test result, and no information linking the youth's identity to the test request or result will be gathered or kept.

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<sup>13</sup> 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure.

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### 5 Agency Protocols for Protecting Confidentiality

Staff should have access to individual identifiable information only if their specific job responsibilities cannot be accomplished without access.<sup>14</sup> Steps that agencies can take to protect confidentiality of health information include:

- Maintain a separate health record.
- Provide in-house training to agency staff on confidentiality regulations. See <http://www.health.state.ny.us/diseases/aids/training/index.htm>.
- Develop and distribute procedures for how these regulations are followed at your site.
- Do not discuss health information about a child on your caseload with colleagues unless they have a “need to know.”
- Do not leave health records on your desk when you’re not using them.
- Communicate carefully with the recipient when mailing/faxing health information so they will be looking for the documents.
- Work with your CONNECTIONS Security Officer to monitor access to health information.
- Make sure caregivers of children with HIV infection are familiar with the redisclosure statement and the laws about redisclosure.
- Suggest that all agency staff (from directors to clerical) sign a “confidentiality contract.”

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<sup>14</sup> 18 NYCRR 357.5(g).

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### 6 Resources

#### HIV and Confidentiality

See Appendix A for the Authorization for Release of Confidential HIV Related Information form (DOH-2557-HIPPA, Rev. 4/03). (For a copy of the form in English and other languages, go to the NYS Department of Health website, <http://www.health.state.ny.us/>, and click on HIV/AIDS).

For the Statewide Calendar of HIV/AIDS Trainings, including training on New York State's HIV Confidentiality Law (Public Health Law Article 27-F), go to <http://www.health.state.ny.us/diseases/aids/training/index.htm>.

The Warning Notice Against Rediscovery of Confidential HIV-Related Information (English and Spanish) can be found in 97-ADM-15 <http://ocfs.state.nyenet/policies/external/1997/>. This ADM is also in Appendix B.

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### *Chapter Eight*

## Maintaining Health Records

Maintaining the health records of children in foster care is critical to providing and monitoring health care on an ongoing basis. When health records are maintained properly, they yield significant information on key health factors such as medical, mental health, and developmental conditions, signs of abuse or neglect, medications, immunizations, and overall health status. With current, up-to-date health records, the agency can evaluate and monitor the quality of care provided to the child; address health problems as they become known; enable caseworkers to make placement decisions that are in the best interests of the child; and develop a service plan that supports optimum health.

When children are placed in care, the first tasks necessary to create a health record are to (1) obtain consent to release past health records; (2) obtain the records; and (3) establish a health file for current and future health activities. This chapter discusses the policies and activities related to past and current records, setting up the health file, keeping the records up to date, using the information in the records effectively, and monitoring health information.



Sections in this chapter include:

1. Obtaining the child's health history
2. The health file
3. The medical home health file
4. Health information in CONNECTIONS
5. NYC ACS health passport
6. Documenting and monitoring health information
7. Resources

**Note:** The term “health record” is used in this manual to indicate all of the information related to the child’s health, including the five assessments (medical, dental, mental health, developmental, and substance abuse). In practice, the term “medical record” is often used in the same way.

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### 1 Obtaining the Child's Health History

At the time of placement (within 24 hours), or before placement if possible, the caseworker must seek consent from the child's birth parent/guardian to release the child's health history.<sup>1</sup> If the birth parent or guardian is unwilling to give consent or is unavailable, the local social services commissioner may authorize release of the child's prior health records.<sup>2</sup>



#### Health Care Coordination Activities

Upon receiving consent to release health records, health care coordination activities include:<sup>3</sup>

- Diligent efforts to obtain records of any previous medical, mental health, or dental treatment. This may include records maintained by the child's school (e.g., immunization records). Be aware that the Medicaid Unit at the local district can access records of claims paid on individual children through the Electronic Medicaid System of New York State (eMedNY). This will help identify past providers.
- Sending written requests with the attached consent for the child's treatment history and records to known health care providers (including hospitals) who have treated the child.
- For any preschool child, making diligent efforts to obtain the child's birth record from the hospital where the child was born or from another hospital in possession of the record.

#### Family Health History

If possible, interview the parents or guardians regarding the child's health history. They could have a wealth of observations and knowledge that may not appear in the child's past medical records. The birth parents' health history should also be obtained, to the extent available. Many health conditions have a hereditary or genetic component. Disorders ranging from diabetes and high blood pressure to alcohol dependence and depression may run in families. It is important to obtain this information and provide it to the child's medical providers. This becomes particularly crucial if the child is later adopted, as the birth parents' health history must be provided upon request to the adopted former foster child and the adoptive parents.<sup>4</sup> (See Chapter 6, *Medical Consents*; also Appendix A for a sample *Health History Interview with Family* form to assist in collecting this information.)

<sup>1</sup> 18 NYCRR 441.22(e); 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

<sup>2</sup> 18 NYCRR 441.22(e).

<sup>3</sup> Ibid.

<sup>4</sup> 18 NYCRR 357.3.

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## 2 The Health File

### Agency Records

For each child in foster care the authorized agency caring for the child must maintain a continuing individual medical history in the case record.<sup>5</sup> If the authorized agency is the LDSS (i.e., the child is in direct foster care), then the LDSS maintains the health record. If the child is in the care of a voluntary agency, that agency maintains the record. The contents of the health record are listed below. All relevant health information, past and ongoing, should be placed in the health file, which becomes the centralized health information resource for the agency.

If foster care services are provided by a voluntary agency, health information in the local social services district need not be so extensive. However, since the local district has ultimate responsibility for the child's welfare, they must maintain a health file adequate enough to properly monitor the child's care. In addition, the voluntary agency staff must send copies of additions to the health file to the local district whenever a *significant* change occurs in a child's health status or treatment but at least no later than the next six-month Service Plan Review.<sup>6</sup> Such changes might include hospitalization, emergency treatment, diagnostic testing, or necessity for extended follow-up care.



#### Health Care Coordination Activities

Facilitate communication between the voluntary agency and the LDSS so that the district has the right amount of information to understand the child's health concerns and properly oversee safety and well-being. Monitor the entry of data into the CONNECTIONS Health Services Module.

The level of information in the health file will vary according to the model of health care provision (i.e., how and where the child obtains health care). If the child is in the care of an agency that provides health care and serves as the child's medical home, the records will be extensive and detailed. In this situation, the health file may serve the dual role of agency health file and provider health file so long as the information is accessible to casework staff (*see section 3, The Medical Home Health File*). If the agency does not provide health care, the agency health file will be separate from the file maintained by the child's primary health care provider, described below in "Provider Records."

<sup>5</sup> 18 NYCRR 441.22(k); 18 NYCRR 428.3(4)(ii).

<sup>6</sup> 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

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Each agency will be responsible for deciding the format and details of the content of the health file. The health file should at least contain:<sup>7</sup>

- Names and addresses of the child's primary and specialist provider(s).
- Original consent forms authorizing medical treatment for the child and the release of medical records to the agency.
- Family health history, including chemical dependency, mental illness, and hereditary conditions or diseases.
- Alcohol, drugs, or medications taken by the child's mother during pregnancy.
- Immunizations received by the child while in care and prior to placement in care (type and dates).
- Medications prescribed for the child while in care and prior to placement in care, and Medication Administration Records.
- Child's allergies (environmental, food, medicine).
- Significant acute, chronic, or recurring medical problems; illnesses; injuries; and surgical operations. Date and place of hospitalization, including psychiatric.
- HIV risk assessment documentation and any HIV-related information.
- Results of laboratory tests, including tests for HIV.
- Durable medical equipment/adaptive devices currently used or required by the child (e.g., wheelchair, feeding pump, mechanical breathing supports, eyeglasses, hearing aids).
- Copies of exam reports from primary providers and specialists while child is in care, including results of diagnostic tests and evaluations in the five assessment domains.
- Updated plan of care that addresses all five assessment domains, including follow-up or continuing treatment provided to, or still needed by, the child.
- Summaries of health care planning meetings.

In addition, required forms are listed in section 7, Resources.

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<sup>7</sup> 90 ADM-21 Foster Care: Medical Services for Children in Foster Care; 18 NYCRR 357.3.

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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### Provider Records

The primary health care provider serving as the child's medical home will keep detailed records in accordance with accepted professional standards and practices. The records should contain pertinent information about the child in care, such as: name, health history, diagnosis, procedures, observation and progress notes, report of treatment and clinical findings, dates of service, and reports on referrals to other providers. The records should be available to the child caring agency or its authorized representatives for inspection, audit, reproduction, excerpts, and/or transcriptions, consistent with consent standards. Specialists will also keep records documenting their assessments, diagnoses, and recommendations for treatment.

Although community providers keep their own health records on the child, they should also record the results of any assessment in a brief and understandable format for use by the agency. This includes the date of the visit, name of the provider, problems identified, plan for further evaluation or treatment, and date of follow-up appointments. Copies of the results should go to the caseworker to be placed in the health file and to the caregiver and birth parent or guardian, if appropriate. Findings and recommendations for follow-up services that result from the visit should be incorporated into the child's case plan and reviewed at each Service Plan Review.



#### Health Care Coordination Activities

Consider developing a "Health Care Provider Summary" sheet for the person accompanying the child to a medical appointment (*see Appendix A for sample summary sheets*). On the summary sheet, the health care provider lists his/her identifying information, the reason for the visit, the findings, and recommended treatment and follow-up, including return date. After the visit, the foster parent or child care staff accompanying the child should give the sheet to the caseworker or agency health staff. If this information is provided immediately in a concise manner, it will not be necessary to send the provider a request for the record of the visit.

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### 3 The Medical Home Health File

In some situations, the child may receive his or her medical care directly from the voluntary agency. If this is the case, the agency is in fact the child's medical home. The health file will be more comprehensive, similar to the provider record described above. The health file should be maintained by qualified health staff and organized in such a way that the information is easily accessible and useable. It is important that documentation be timely, comprehensive, and accurate. Since the health file is the legal record for all health services provided to children in foster care, it must be legible and available for continuity of care, monitoring, and oversight. Encourage staff who enter information to use ink, write legibly, document at the time of service, and date all entries.

**Note:** The information contained in a foster child's health file is confidential (*see Chapter 7, Confidentiality of Health Information*).

Although there is no prescribed method of organization, the medical home health file may be stored in a loose-leaf three-ring binder with tabbed dividers including sections such as:

- Face Sheet\*
- Consents
- Medical documentation from hospital/clinic visits
- HIV Risk Assessment
- Medications
- Medical Assessment/Immunizations
- Dental Assessment
- Mental Health Assessment/Psychiatric Medications
- Developmental Assessment
- Substance Abuse Assessment
- Laboratory Reports
- Past Health Records
- Health Education
- Health Care Coordination Activities (includes required notices and other communications)

\*The Face Sheet, containing critical information at a glance, can be very useful to staff reviewing a child's health file. Include the child's name, current placement, name of primary provider, any active problems, allergies and other chronic health problems, blood type, durable medical equipment, recent hospitalizations (with dates), insurance information, and emergency contact number.

Congregate care: The health file should include:

- Face sheet
- Nurse triage form
- Nursing progress notes
- Medication Administration Form
- Medical documentation from hospital/clinic visits

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- Physician referral, if necessary
- Child's available record (immunizations, screening results)
- Consultation forms

To organize the health file, consider the functions it serves of collecting, recording, and conveying information. Be sure to file records in chronological order within each section.

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### 4 Health Information in CONNECTIONS

The Health Services Module in CONNECTIONS allows the child's case manager, case planner, agency nurse, or health care coordinator easy access to the most critical health information for the child. It is not intended to be a comprehensive health record or a substitute for the medical records maintained by the social services district, authorized agency, or the child's medical provider, as described in the previous two sections. Because it is not necessary to enter all of the child's medical appointments or services into the system, the external health file will be the more complete record. The child's medical providers will have the most comprehensive record of all.

Entering and updating the following health-related information in the Health Services Module is required for all children in foster care and all children in OCFS custody placed in an authorized agency. Required fields should be completed as soon as the documentation is received from the provider.

#### Required Fields<sup>8</sup>

1. Designate health responsibility
2. Child Health Info tab

To support the accuracy of critical health information, records from health providers must be in the agency's possession when entering information on an overnight hospitalization. Written documentation in the child's medical record, or verification from the prescriber or the prescription itself must be obtained before entering medications into the system. This is particularly critical as many medications have similar spellings. Allergies and durable medical equipment reported by the parent/guardian must be entered into the system pending verification by a health provider. If dates for the onset of allergies, the use of durable medical equipment, and the first prescription of a medication for a chronic condition are unknown, they may be estimated using the protocols described in the CONNECTIONS Job Aid <http://www.ocfs.state.nyenet/connect/jobaides/jobaides.asp>. This information must be updated whenever it changes.

Required fields on this tab are:

- Current allergies, medications, and durable medical equipment with start and end dates, as applicable.
- All overnight hospitalizations while the child is in foster care.

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<sup>8</sup> 08-OCFS-ADM-01.

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- To the extent known, overnight hospitalizations prior to foster care which are related to chronic health conditions or conditions that led to the child's removal.
- After Hours Agency Health Contact, as applicable.
- Primary Care/Medical Home provider.

### 3. Clinical Appointments tab

To support the accuracy of critical health information, records from health care providers must be in the agency's possession when entering data on clinical appointments. If an appointment must be entered, any diagnoses identified by the medical practitioner during that appointment must also be entered.

The following information must be entered into this tab:

- Initial assessments in five domains (physical/medical, dental, developmental, mental health, and substance abuse for children 10 years of age and older) for any child who entered foster care within the 90 days prior to the date the district implements the Health Services Module, and every child who enters foster care thereafter.
- Periodic well-child care (physical/medical domain).
- Periodic preventive care (dental).
- "Immunizations up to date" indicator for initial and well-child physical/ medical appointments.
- Discharge exam (use the "Well child" appointment type).
- The initial diagnosis of a chronic health condition. If diagnosed prior to entry into care, use the "Diagnosis at Intake" appointment type.
- All "Emergency Care" and "Crisis Intervention" appointments.
- Provider name and address for all appointments entered.

### 4. Early Intervention tab

The Early Intervention (EI) tab must be completed for any child under the age of three in an open Family Services Stage who was involved in an indicated CPS report. Unlike other parts of the Health Services Module, the EI tab is not subject to enhanced security. If the child receives an EI evaluation, record it as a developmental assessment in the Clinical Appointments tab in addition to completing applicable fields in the EI tab.

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The following information must be entered into this tab:

- Early Intervention referral date for all children under 3 in an indicated CPS case.
- All other fields as applicable for referred children.
- Information on this tab must be entered prior to the child's 4th birthday.

### 5. Bio Family Health tab

Health information on a parent or biological relative should be obtained from the health care provider pursuant to a release signed by the parent or person whose records are requested prior to entering this information into CONNECTIONS. If records cannot be obtained but the information is credible, enter it into the Bio Family Health tab. Put a brief note in the additional information box stating that documentation verifying the diagnosis could not be obtained and why the diagnosis is believed to be credible. Information on the HIV status of a family member should *not* be entered into CONNECTIONS.

The following information must be entered into this tab:

- Hereditary conditions and allergies of the child's biological family.
- Information on the biological family's health history that could impact the child's current or future health.
- Information on the biological mother's pregnancy for this child.
- Parent's cause of death, if applicable. If the parent died as a result of HIV/AIDS, record the exact illness (e.g., Pneumonia) if known, or a general term such as Infectious Disease, if unknown.

### 6. HIV Risk Assessment

All children in foster care must be assessed for HIV risk, and the results of that assessment must be recorded on the HIV Risk Assessment tab. This tab is used for children in foster care *only*.

The following information must be entered into this tab:

- All risk assessments completed for children in foster care in accordance with OCFS regulation.
- All fields as prompted by system logic.
- Test date and results for Newborn Screening and confidential HIV tests.

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### 7. Health Narrative

The Health Narrative may be used to record health information that is not appropriate to record in Progress Notes. This includes:

- Any information related to HIV/AIDS services.
- Quotes from the substance abuse provider's reports or notes.
- Quotes from mental health provider's reports or notes.
- Confidential reproductive health services, including STDs.

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### 5 Health Passport

Foster parents must receive a summary of health information, such as a health passport or its equivalent, for each child.<sup>9</sup> A health passport is an abbreviated health record that accompanies the child from placement to discharge (*see section 7, Resources*). Foster parents should take the passport to all health appointments and ask the provider to fill in the information. They should also take it to any Emergency Room visits. When the child is discharged from foster care, remember to give the health passport to the discharge resource (birth parent, guardian, adoptive parent, or child if appropriate).

Information to be collected for the health passport should include:

- Child's health status before placement.
- Documentation of medical, dental, and mental health services provided while in care.
- Names and addresses of past and current medical, dental, and mental health care providers, such as physicians, pharmacies, or opticians.
- Parents' names and their medical histories.
- Child's current medications and serious medical conditions such as allergies.
- Durable medical equipment/devices required, such as glasses, hearing aid, braces, wheelchair.
- Child's health history, including date of birth, hospital of birth, birth weight and condition, childhood diseases, chronic health problems, hospitalizations, immunizations, educational history, developmental history, functional history, and immediate family health history.

Information should be entered onto the health passport as soon as it is available. Review the health passport at least once every six months to assure that appropriate entries have been made. *To be useful, the health passport must be kept up to date.*

Caseworkers, caregivers, and health providers should be trained in and familiar with the use of the health passport, emphasizing its importance to the well-being of the child.

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<sup>9</sup> 18 NYCRR 443.2(e).

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### 6 Documenting and Monitoring Health Information

To monitor health services and staff activities regarding health of children in foster care, agencies should have procedures specifically related to health records and information. Procedures should reflect the following goals:

- Document all health services provided.
- Maintain health records in a fashion that encourages their use.
- Protect the confidentiality of health records.
- Track caseworkers' activities in meeting the health needs of children on their caseload.
- Review health records and health care plans regularly and incorporate them into the Family Assessment and Service Plan (FASP) for the ongoing service needs of the child.
- Collaborate between and among service providers to integrate their contributions with the child's health plan.
- Support health care coordination activities to abstract, summarize, and review health care plans; recommend health-related policies and procedures; consult with caseworkers on an individual case; and monitor the health status and quality of health care being provided to children in care.
- Facilitate data collection and record-keeping procedures so that health histories are accessible and available, current health status and health plans can be easily reviewed, and overall system-wide health data can be examined.

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### 7 Resources

#### Health Passport

The New York City Administration for Children's Services (ACS) provides its foster parents with a medical passport for each child in care. The passport documents the child's name, date of birth, Social Security number, name and address of parent/guardian, doctors' names, addresses, and telephone numbers, type of insurance, CIN number, name of agency, date of placement, foster parent's name, etc. Medical information includes prenatal history, family history, immunizations, and screening tests.

On the inside front cover of the passport is a message from ACS to foster parents:

The goal of the medical passport is to capture pertinent health information about your child that would assist health care providers to understand the health history and status of your child for appropriate intervention. It is meant to enhance communication among those responsible for his/her care (including caregivers, medical providers, and agencies) and promote continuity and coordination of health care. This is a lifetime health record that belongs to your foster child summarizing critical health information.

- Please bring this passport with you every time your foster child visits a doctor or any medical provider, including mental health providers. Ask them to record the visit and their findings here.
- Your child will need this record for the future.
- Make sure it accompanies the child if he/she moves to a new foster boarding home (FBH).
- As a foster parent, you do not have the right to consent for treatment. Consent should be sought from the agency.
- Information on this passport is confidential and should not be shared with anyone other than providers responsible for the health care of your children, the foster care agency staff, and ACS staff.
- Keep this passport in a safe place.

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### Agency Forms and Notices

The health record should also include the following required information and notices:

**Form DSS-711, Child's Medical Record, or copies of a comparable medical record form.** This form is no longer in wide use, and many physicians have designed forms for their own use. Any such forms are acceptable as long as they record the results of the initial and periodic medical assessments given the child.

**Medical Report on Mother and Infant.** A request for all prenatal and birth information available for each preschool child placed in foster care must be submitted to the appropriate hospital or physician. A consent release must be attached. Diligent effort must be made to obtain such information, which should be retained in the case file.

**Progress Notes.** Progress notes related to health may be entered into CONNECTIONS. Use the Health Narrative for confidential information, as described in section 4 above. Notes may also be maintained in the health file. Activities to be noted include the dates of medical and dental appointments, examinations and services, a record of referrals, follow-up activities, and transportation provided by the authorized agency. It is not necessary to summarize the child's medical record or results of examinations since the examination record forms must be retained in the same file.

**Consent forms.** Signed consent forms for release of prior health history, for routine medical or psychological assessment and treatment, and for emergency medical or surgical care (when the parent or guardian cannot be located at the time the care is necessary) must be kept in the child's health file (*see Chapter 6, Medical Consents*).

**Family planning notices to foster parents.** A copy must be kept in the child's health file to indicate that the required notice of family planning services has been sent within 30 days of placement to all foster parents caring for children 12 years of age or older. This notice, which must also be sent annually to such foster parents, informs them of the availability of social, educational, and medical family planning services for the adolescent.<sup>10</sup>

**Notice of family planning services directly to adolescents (optional).** If the local social services commissioner has approved a district-wide plan to make an offer directly to all adolescents in foster care within his or her jurisdiction of family planning services, a copy of the information provided to the youth must be kept in the health file (*see Appendix A for a sample notice.*) The availability of these services may be discussed orally with the youth but must also be offered in writing. If your district has this policy, it must be implemented across the entire county.

**Notice of C/THP services.** Within 60 days of entry into foster care, if the child is Medicaid eligible, the local district must notify in writing the foster parents, or the institution, group residence, group home, or agency boarding home of the availability of Child/Teen Health Plan (C/THP) services. A

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<sup>10</sup> 18 NYCRR 463.2.

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copy of the notice must be kept in the child's health history file. This written notice must also be provided to the caregivers of the child at least annually.<sup>11</sup>

**CONNECTIONS** Enter required data on each child in foster care into the Health Services Module, as outlined in section 4 above.<sup>12</sup>

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<sup>11</sup> 18 NYCRR 507.1.

<sup>12</sup> 18 NYCRR 466.3

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### *Chapter Nine*

## Working With Community Health Care Providers

Children in foster care need a primary health care provider, as well as specialists, including dentists, mental health professionals, optometrists, orthopedists, and others accessible within the surrounding community served by the foster care agency. In addition to identifying a range of health care providers, agencies often need to establish relationships with certain specialists according to the population served by the agency (e.g., an obstetrician-gynecologist for teens). This chapter explores the issues related to working with community health care providers.

As noted throughout this manual, children are best served when one primary care provider handles their health care throughout (and preferably after) placement – known as a “medical home.” The medical home is enhanced when the provider also makes referrals to specialist(s) who come to know the child and his/her health care needs over time.

An important choice confronting agencies is whether to mandate the use of certain health care providers who have been identified in the community or to encourage foster parents to use providers they already know and trust. A third option may be to combine both approaches: Identify and establish or continue relationships with providers, including those already used successfully by foster parents.



Sections in this  
chapter include:

1. Identifying and engaging health care providers in the community
2. Establishing and maintaining relationships with health care providers
3. Service agreements
4. Billing policies and practices

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### 1 Identifying and Engaging Health Care Providers in the Community

It is important to encourage the use of community health care providers that foster parents are comfortable using. Ideally, for continuity of services, the child will go to the same provider, throughout his or her placement.

Before identifying appropriate health care providers, the first step for the agency is to understand its own needs and be able to communicate them to prospective providers. It is also critical that representatives of the agency be able to explain the health program for children in foster care and how it differs from community health care.



#### Health Care Coordination Activities

Meet with providers on a one-to-one basis to (1) explain your agency's needs and population; (2) discuss the unique situation presented by children in foster care; and (3) learn about the provider and his/her ability and willingness to treat children in care, as specified in the criteria listed below.

Although it takes time to meet with providers, in the long run the benefits to you, the agency, the children in care, and their caregivers will be apparent in terms of both continuity of care and ease of communication. Some foster parents will already have established relationships with certain providers. Meeting with these providers would be good practice as well.

### Laying the Groundwork

Establishing a relationship with providers is a process that occurs over a period of time. Make the effort to understand each other's perspectives, needs, and operational considerations. Here are some ways to lay the groundwork for a mutually positive and beneficial working relationship:

- Meet with all providers face to face, both initially and periodically.
- Describe your agency and its mission, functions, and organizational structure.
- Give providers a copy of Chapters 1, 2, and 3 from this manual or equivalent information (e.g., *Fostering Health*) that outlines the expectations for health care for these children.
- Review your agency's needs and the needs of the provider.
- Follow up on all outstanding issues raised during the initial and any follow-up meetings.

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- Develop written service agreements as needed (*see section 3, Service Agreements*).
- Stress the importance of communication to reduce problems that may arise when caring for children in foster care (e.g., consent, reimbursement, missed appointments).
- Assure providers that you will be accessible, as needed.

### Criteria for Selecting a Community Health Care Provider

To determine whether health care providers are willing and qualified to treat children in foster care, consider the following criteria:

- Demonstrated competence in general medicine or in specialized pediatric or adolescent care.
- Demonstrated competence in the management of behavioral and developmental problems in children and adolescents.
- Willingness to see children for initial health assessments, court-ordered exams, AWOL exams, and discharge exams.
- Medical specialty board eligible or certified with admitting privileges at local hospital (for physicians) for complex cases and special health needs.
- Willingness to provide appropriate documentation for the court, and to testify, if needed.
- Willingness to invest the time necessary to involve birth parents, caregivers, caseworkers, school personnel, medical consultants, and others concerned with the health and well-being of the child.
- Willingness to report missed appointments or lack of treatment follow-through to agency staff.
- Availability for telephone advice during evenings and weekends.
- Sensitivity to cultural and ethnic differences.
- Stated willingness to participate in interdisciplinary meetings involving social workers, attorneys, psychologists, school personnel, and others concerned with the well-being of the child.
- Sensitivity to the special emotional needs of children in placement (e.g., feelings of loss and abandonment).
- Willingness to make referrals for specialty cases (e.g., sexual abuse assessments).
- Willingness to coordinate care among specialty providers (e.g. cardiology, ophthalmology).

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- Willingness to develop a written health plan for each child.
- Willingness to provide timely and clearly written health information to the agency.

### Engaging Health Care Providers

To attract and engage health care providers the agency has selected to work with, inform them that you will:

- Negotiate fees that are competitive with local standards (through the Medicaid per diem).
- Guarantee a certain number of children or visits by working with caregivers to keep appointments.
- Be a contact person who is responsive to their needs.

The third point – being a resource for the provider – includes providing medical information and records, solving problems, and supporting the foster parent. Health care providers will want to know that they have a contact within the agency if the foster parent does not have the relevant information, is missing appointments, or is not following through with medications or other prescribed treatment.

In addition, let providers know that you will inform them of significant changes and events such as:

- Changes in the child's placement.
- Changes in the child's permanency status or goal.
- Emerging health and mental health issues not previously identified.
- Emergency room visits.

### Addressing Concerns About Foster Care

To attract some health care providers, it will be necessary to address their concerns about treating children in foster care. Health care providers may not wish to care for children in foster care for a number of reasons:

- Frequent missed appointments.
- Incomplete health history.
- No consent for care or for release of medical records.
- Inadequate reimbursement for the amount of work or time required to provide care.
- Misperceptions about children in the child welfare system.

Some providers may have experienced these situations in the past, while others may have heard about them from colleagues. By reducing or eliminating some of these concerns, you can help providers with their decision to treat children in foster care. For example, you can tell providers that you will

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stress to foster parents the importance of keeping all health-related appointments (accompanying them on the first visit if possible), obtain complete past health records, and obtain consents. You can also inform providers that they will be reimbursed at competitive rates. By educating providers about foster care and its purpose, you will allay their concerns.

### Developing a List of Health Care Providers

The local department of social services is responsible for maintaining a current listing of the names and locations of medical providers who will treat children eligible for the Child/Teen Health Plan (Medicaid). This list must be available to foster parents and authorized agencies.<sup>1</sup> Voluntary agencies should also consider developing a list of providers with whom they have an ongoing working relationship. Practitioners should be located within a reasonable distance of most foster homes and other foster care facilities in your community. Although some specialists may be located farther away, it is critical to include specialist providers.

Whether or not they accept Medicaid, the providers should include those you have visited and with whom you have developed service agreements. Update the list regularly and give it to caregivers and agency staff. The list will help caseworkers learn how health services in the community are organized. Finally, tell providers you have a list. Share it with them so they can see that their colleagues are also working with children in foster care.

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<sup>1</sup> 18 NYCRR 441.22(h)(2).

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## 2 Establishing and Maintaining Relationships with Health Care Providers

An effective medical home facilitates a comprehensive, coordinated treatment approach by all professionals involved in the child's care. Establishing and maintaining ongoing relationships with community health care providers will facilitate the medical home process.

### Providing Information for Initial Health Evaluation

It is recommended that a caseworker or health staff accompany children on their initial health assessments. Agency staff will give the health care provider the consent form, release of medical records form, and medical records; if unaccompanied by the agency, the foster parent should have these materials and give them to the practitioner. Also consider giving the foster parent a cover letter that introduces them and the child to the provider on the first visit.

For each new admission, the health care provider should be given the following:

- Signed consent form.
- Signed release of health records forms.
- As much previous health history as possible (e.g., prior health records, immunization records, birth records for an infant, records from inpatient hospital stays) (*see Chapter 7, Confidentiality of Health Information*).
- Names and telephone numbers of previous health care providers.
- An overview of billing practices (*see section 4, Billing Policies and Practices*).
- Contact information for the caseworker or agency.



#### Health Care Coordination Activities

Consider developing a “Health Care Provider Visit Record” form for the person accompanying the child to a medical appointment (*see Appendix A for sample visit record forms*). On the visit record form, the health care provider lists his/her identifying information, the reason for the visit, the findings, and recommended treatment and follow-up, including return date. After the visit, the foster parent, if accompanying the child, should give the form to the caseworker or agency health staff. Having this information provided immediately in a concise manner will be helpful in coordinating health services for the child.

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### Establishing Relationships with Emergency Rooms

There are several important issues to address when establishing a relationship with emergency rooms. Explain consent protocols and establish agreement on the type of documentation the emergency room will need to treat children in the care of your agency. Then be sure that as soon as they arrive, foster parents or childcare staff inform the emergency room that the child is in foster care, and have the appropriate information with them. Establish agreement with the emergency room regarding notification to the LDSS or voluntary agency and how this will be accomplished. Be clear that even if there are delays in establishing consent, they should proceed with necessary emergency care.

Explain that the billing protocol for emergency room services is to bill Medicaid (eMedNY). It is recommended that voluntary agencies with a Medicaid per diem provide the MA number to the emergency room when the agency is notified, rather than giving the number to foster parents.

In addition to consent and billing needs, communication is an important issue. Be sure to inform foster parents that they should always contact the agency in emergencies so that agency staff are aware of the health issues of the children in their care and why emergency room care was needed. This routine communication may also alert agencies to inappropriate use of the emergency room. In addition, try to establish agreement with the emergency room to routinely send ER records or summaries of treatment and follow-up to the agency medical director or the established health care provider (medical home) for the child.

### Follow-Up Activities

To coordinate follow-up care after the initial health assessments, review the health file to determine whether further diagnostic testing, referrals, or treatment have been recommended.



#### Health Care Coordination Activities

In relation to the health care provider, health care coordination activities include:<sup>2</sup>

- Contacting the provider, if necessary, to obtain information on follow-up care and treatment.
- Offering to assist the foster parent with follow-up care and transportation.
- Encouraging the provider to contact the agency about follow-up, referrals, missed appointments, or other important information.

To maintain a good working relationship, re-assess your agency's needs and the needs of the health care provider regularly. Meet with practitioners on a regular basis (e.g., once a year) to confirm that

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<sup>2</sup> 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

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visits, billing procedures, and referrals are going smoothly and to provide updated information about the agency health program in general.

When meeting with foster parents or childcare staff, ask them about the quality of care being provided and their satisfaction with the provider and the service. For instance, does the provider listen to the child's as well as their concerns? Are appointment times honored? Is the location convenient? If there are problems, you may need to talk with the health care provider to identify reasons and solutions. Some agencies find that administering questionnaires to caregivers and providers is a useful way to gauge satisfaction with current provider arrangements. Your agency may wish to consider doing this. It is important to keep communication open to facilitate good working relationships with providers. Communication also gives you an opportunity to address concerns before they become insurmountable.

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### 3 Service Agreements

In some circumstances it would be in the best interest of the agency as well as the health care provider to develop service agreements (*see Appendix A for a sample service agreement*). Service agreements can help define the nature of the business relationship.

1. A service agreement can help negotiate a special financial relationship. For instance, voluntary foster care agencies operating with a Medicaid per diem may be able to negotiate less expensive rates for a large quantity of service needs (e.g., laboratory work).
2. If the agency has an arrangement with a community health care provider to serve children in foster care at a particular time and location, a service agreement may be of some value when unexpected circumstances arise. For instance, when the practitioner goes on vacation, a service agreement could ensure back-up coverage.
3. Service agreements with large medical organizations, including emergency rooms, may help clarify issues related to consent, billing, and sharing of records.

Services that may be specified in a provider agreement include:

- Basic service and benefits to be provided.
- Provisions for emergency care.
- Periodicity schedules for routine well child care.
- Protocols for the content of initial and follow-up assessments.
- Specifications for information to be included in medical records or reports to be submitted to the agency health record.
- On-call services, including evening and weekend coverage.
- Provision of specialty exams, such as those following AWOL or before discharge.

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### 4 Billing Policies and Practices

#### Tips for Foster Parents

Make sure that foster parents know that they should *not*:

- Put their own name on medical bills (always name the agency as the responsible party).
- Sign anything related to medical consent, treatment, or billing.

#### Billing Arrangements

Financing of health care services for children in foster care is complex. Billing arrangements vary depending on whether the child is in the care of a local department of social services or a voluntary agency. Within the LDSS or voluntary agency, arrangements also vary depending on choices made by the district or agency, as described below.

Effective January 1, 2005, all children who are in the care and custody of the local district commissioner, and who are citizens or have satisfactory immigration status, are eligible for Medicaid (MA). In addition, children adjudicated as juvenile delinquents pursuant to Article 3 of the Family Court Act (FCA) and placed in the custody of OCFS, pursuant to Section 353.3 of the FCA, and who are citizens or have satisfactory immigration status, are eligible for Medicaid.<sup>3</sup>

Establishing eligibility for Medicaid is crucial for children in foster care to have access to health care and related case management services. In all cases, the local district is responsible for establishing the child's eligibility for Medicaid. If the child is deemed eligible, the district assigns a Medicaid number to the child.

All agencies need to have policies in place for this process. Local districts must have policies to facilitate timely MA eligibility determinations for children in foster care as well as redetermination policies to provide continuous coverage. Voluntary agencies need policies to establish that Medicaid is active when children come into foster care and to know who to contact for any issue related to the child's Medicaid eligibility.

The local district is also responsible for the appropriate system entries into the Welfare Management System (WMS) to process payment to voluntary agencies with a Medicaid per diem rate (*see below Children in Indirect Care*)

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<sup>3</sup> GIS 05 MA/041.

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### Children in Direct Care

Approximately one quarter of children in foster care in New York State are in the *direct care* of the local social services commissioner. In most counties, health care for children in direct care is reimbursed by Medicaid on a fee-for-service basis, and each child is issued a Medicaid card.<sup>4</sup> Access to health care services is limited to those practitioners enrolled in eMedNY. eMedNY is the name of the New York State Medicaid program claims processing system. The system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible clients.

In 1997, New York State offered some counties the opportunity to enroll some or all children in direct foster care in Medicaid Managed Care. Several counties with smaller foster care populations chose this option in an effort to manage costs, improve access, and improve tracking. Counties must apply for and be approved by the Department of Health's Office of Managed Care before enrolling children in foster care in a managed care plan.

Therefore, the local social services commissioner has two options:

1. **Medicaid Fee-For-Service system (MA card).** Under the fee-for-service system, children are obligated to use Medicaid-enrolled providers, and the providers bill eMedNY directly. Children are issued a Medicaid card. It is important that local district staff communicate with one another so that the Medicaid eligibility determination is done and appropriate WMS systems entries are made, including the address where the card should be sent (the caseworker or the foster parent).
2. **Medicaid Managed Care.** For the local district to enroll a child, it first needs to obtain approval from the New York State Department of Health. The district will need to submit a "Foster Care Enrollment Plan," which describes the policies and processes that will be used to enroll direct care children in Medicaid managed care. The district may choose to enroll children on a case-by-case basis. For information, contact the Office of Managed Care at 518-473-0122. Once approved, district staff must communicate with one another so that the Medicaid eligibility determination is done and appropriate WMS systems entries are made, including proper enrollment and disenrollment entries.

### Children in Indirect Care

(placed with voluntary child caring agencies)

The remaining children in foster care in New York State are in the care of voluntary agencies that operate their foster care programs under contract with individual local departments of social services (known as *indirect care*).

Children in foster care placed with a voluntary child care agency are statutorily excluded from Medicaid managed care. Therefore, agencies have two options:

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<sup>4</sup> Common Benefit Identification Card (CBIC).

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1. **Medicaid Per Diem Rate.** The agency pays for health care services out of the agency's Medicaid per diem rate. The child is not issued an MA card but has an MA number.
2. **Fee for Service.** The agency uses health care providers who accept Medicaid and bill directly to eMedNY. The child is issued an MA card.

In most cases, voluntary agencies are paid a Medicaid per diem rate to provide comprehensive health services to each child in their care. Out of the Medicaid per diem rate (established by the NYS Department of Health), the agency is expected to pay for most of the child's health care services. Certain services, including emergency room and hospitalization, are always billed directly to eMedNY. Refer to the *Child (Foster) Care Agency Provider Manual* at <http://www.emedny.org/ProviderManuals/ChildCare/index.html> for more information. Children are not issued a Medicaid card but have a Medicaid number. Since a per diem rate offers an agency the greatest flexibility and management over service utilization, agencies should be encouraged to obtain a per diem.

If your agency uses a Medicaid per diem, be aware that certain medications for foster children can be billed directly to eMedNY by the pharmacy. A list of these "carveout" prescriptions may be found on the Department of Health website:

[http://www.health.state.ny.us/health\\_care/medicaid/program/carveout.htm](http://www.health.state.ny.us/health_care/medicaid/program/carveout.htm). Check this website regularly for updates to the list.

Voluntary agencies without a Medicaid per diem must use health care providers who accept Medicaid and bill directly to eMedNY.

**Tip:** It is good practice to obtain information about the visit from the health care provider before authorizing payment for a bill. If the provider does not include a summary with the bill, the agency may send the bill back with a note that the record must be enclosed. Consider having your agency implement this procedure, which would require a prior arrangement with the health care provider.

## How To Obtain a Medicaid Per Diem

As New York's Single State Medicaid agency, the Department of Health (DOH) determines Medicaid per diem rates for authorized foster care agencies. The health needs of children in foster care vary in severity across different agency programs; some programs within the agency spend more per child on health services than other programs. To support agencies in providing optimal care, a Medicaid per diem rate setting methodology has been established that includes a detailed application package and careful review by a panel of health professionals across relevant state agencies. The panel can request additional information, and OCFS provides a recommendation to DOH on the rate request.

The objectives of the Medicaid per diem methodology are to:

- Reflect costs that adequately reimburse agencies for medical services necessary to meet the needs of the children in care.

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- Provide equitable distribution of available resources among all childcare agencies that are providing services in an efficient fashion.
- Be sensitive to the unique or unusual medical needs of certain groups of children with special medical conditions.
- Reflect reasonable costs of programs that are efficiently operated and should be relatively easy to administer.

To achieve these objectives, the foster care population is divided into two major groups for purposes of determining medical costs:

1. The General Care Population, representing children in foster care residing in institutions, group residences, group homes, agency-operated boarding homes, and foster boarding homes, whose medical and clinical needs are largely routine.
2. Special Populations, representing seven discrete groups of children with special medical needs.
  - AIDS children
  - Boarder babies
  - Diagnostic
  - Hard-to-place
  - Maternity
  - Therapeutic boarding home
  - Special other

Agencies identifying such special populations for the first time are required to submit an Application for Discrete Medicaid Rate, providing programmatic and budget narrative justifying the need for a Special Population rate (*see Appendix A for the Application*). The Application is submitted to your OCFS Regional Office, along with a completed DOH-4224 NYS DOH *Medical Services Expenditure Distribution Sheet – General Care* (previously DSS 2660) or DOH-4225 NYS Department of Health *Medical Services Expenditure Distribution Sheet – Special Care* (previously DSS 2660-01).

The Application for Discrete Medicaid Rate describes the clinical characteristics of the children and their medical needs, and a budget justification. The Medical Services Expenditure Distribution Sheets, which are completed annually by the child care agency and submitted to OCFS, are used for determining Medicaid per diem rates.

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### *Chapter Ten*

## Supporting Caregivers

Foster parents and childcare staff have a crucial role to play in maintaining the health of children in their care. Ideally, the caregiver and agency work together with health care providers and other professionals for the benefit of the child. In working together, caregivers have responsibilities to carry out as well as rights to certain actions by the agency, both of which are outlined in this chapter.

The function of health care coordination goes a long way in providing that the caregiver supports the health plan for the child and that information is shared appropriately among caregivers, agency staff, parents or guardians, and providers involved in the child's care.

This chapter describes formal and informal ways of supporting caregivers in maintaining and monitoring children's health, relating to health care providers, and keeping informed about health issues. To implement these methods of supporting caregivers, some districts and agencies will want to re-examine their current practices, meet with cooperating agencies to discuss joint efforts, and/or put in place policies that incorporate new approaches.



Sections in this chapter include:

1. Being part of a team
2. Transportation
3. Information
4. Health/mental health training
5. Foster parent associations and support groups
6. Resources

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### 1 Being Part of a Team

Foster parents are part of a “team” working together for the child’s well-being and permanency. The team should also include the caseworker, agency health care coordination staff, health care providers, other service providers, the birth parents or guardians, and the child when appropriate. The message to foster parents should be: *You are not alone in caring for a child. You have support. It also means that you need to keep the agency up to date on the child’s health.*

As part of their overall responsibilities as caregivers, foster parents are expected to cooperate with the caseworker in carrying out the health plan, communicate with the caseworker when health issues arise, and attend any meetings called to discuss the child’s health needs. It is important for foster parents to attend Service Plan Reviews since the child’s medical, mental health, developmental status, and other health-related factors are discussed, and input from foster parents is valuable.

In their health-related role as members of the team, foster parents are responsible for:

- Working with agency staff in arranging for the child’s ongoing and/or special health care.
- Transporting and accompanying the child to appointments whenever possible.
- Carrying out prescribed treatment and/or referrals.
- Welcoming in-home services, such as those provided through EIP and B2H.

In working with foster parents on health issues, agency staff are responsible for providing practical and emotional support, including:

- Offering to assist with scheduling appointments and transportation.<sup>1</sup>
- Providing information on required health activities and time frames.
- Providing or locating specialized health information and training when needed.
- Helping foster parents identify and negotiate with health care providers.
- Informing foster parents about medical consent and emergency care.
- Informing foster parents about billing and payment.
- Answering questions and providing resources (e.g., stickers for poison control).
- Requesting and respecting foster parents’ opinions and observations about the child’s well-being.
- Listening and being available especially during difficult periods of illness or disability.

Other types of support include visits to the foster home by a nurse care manager, referral to support groups, accompanying foster parents to specialty clinic visits to assist in interpreting and understanding prescribed treatment recommendations, and providing a 24-hour telephone number for foster parents and families to address crisis situations.

**Tip:** Be aware of the cultural, ethnic, and religious needs of caregivers and how those factors may impact the caregiver’s perceptions of the child’s medical needs. Be sure to address home remedies or traditional treatments that the caregiver may wish to use.

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<sup>1</sup> 18 NYCRR 441.22(j)(2); 507.1(c)(5).

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## 2 Transportation

Foster parents are expected to transport and accompany children in their care to their routine medical or other appointments whenever possible. Teens, however, may go to family planning appointments alone. Reinforce to foster parents that they know the child's needs and that they can be a comforting and familiar presence for the child especially during stressful appointments. Encourage them to tell the caseworker if the appointment does not go well or they are uncomfortable with the provider.

For children eligible for Medicaid, agencies must provide transportation and other related travel expenses, if necessary.<sup>2</sup> Travel expenses include the cost of transportation by ambulance, invalid coach, taxi, common carrier, or other appropriate means; the cost of outside meals and lodging (en route to, while receiving, and returning from medical care); and the cost of an attendant to accompany the child, if medically or otherwise necessary.<sup>3</sup>

Be sure to explain that prior approval from the caseworker is needed for nonemergencies and that decisions about reimbursement are made in partnership with the agency.

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<sup>2</sup> 18 NYCRR 507.1(c)(5).

<sup>3</sup> 18 NYCRR 505.10.

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### 3 Information

When caregivers are informed about health care and confident of their ability to perform medical activities (e.g., dispense medication), they will be more effective in their role. Helping them be informed benefits everyone – the child, caregivers, agency staff, and health care providers.

Information is an important source of support for caregivers throughout placement. Even before certification, prospective foster parents need to be informed about the range of possible health conditions of children who might be placed in their homes. Foster parent recruiters should describe clearly the realities of caring for children with special needs as well as the support available from the agency and other sources, including special and exceptional board rates.

When asked to care for a specific child, foster parents must receive health (and other) information about the child that is as complete as possible.<sup>4</sup> As described in Chapter 1, Initial Evaluation of Child's Health, obtaining the child's health records and history is a priority before or at the time of placement. When the health history is available, the homefinder or other caseworker should inform the foster parent about any relevant support services.

**Note:** In an emergency placement, the caseworker may need to explain that because of circumstances the child's health history is not available but will be obtained as soon as possible. If there is information in the CONNECTIONS health module, a Health History Report can be generated to give the foster parents.

The agency is responsible for providing caregivers information about:<sup>5</sup>

- Periodicity schedule for health visits, including immunizations.
- Agency's procedures for obtaining medical care in cases of suspected illness.
- Agency's procedures for securing emergency medical treatment.
- Information related to whether the child has had an HIV-related test or has been diagnosed as having AIDS, an HIV-related illness, or an HIV infection.

Agencies are also responsible for notifying caregivers about certain services:

- For foster parents caring for children 12 years of age or older, the availability of social, educational, and medical family planning services for the adolescent.<sup>6</sup>
- If the child is eligible for Medicaid, the availability of Child/Teen Health Plan (C/THP) services, and, upon request, the names and locations of providers offering these services.<sup>7</sup>

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<sup>4</sup> 18 NYCRR 443.2(e).

<sup>5</sup> 18 NYCRR 441.22(j)(1).

<sup>6</sup> 18 NYCRR 463.2(b).

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Some agencies develop handouts with helpful information on obtaining health care and time frames that foster parents need to know. Examples include the immunization schedule; time frames for evaluations; information on making medical appointments, consent issues, and health records; medication guide; side effects of psychiatric drugs; and tips on cleanliness and hygiene.

### Emergencies: Tips for Foster Parents

Agencies must inform foster parents of procedures for obtaining care for suspected illness or medical emergencies.<sup>8</sup> In foster parent training, handbooks, and case contacts, cover what constitutes an emergency, and inform foster parents of procedures for calling “on-call” staff or going to the emergency room (*see section 6, Resources, for a sample Emergency Fact Sheet for foster parents*).

Tips for foster parents include:

- Call the on-call worker to:
  - obtain consent if necessary.
  - obtain appropriate billing information (e.g., Medicaid number).
  - let the agency know that follow-up may be needed.
- Bring the child’s medications, including allergy medications.

Explain that visits to the emergency room should be reserved for true emergencies. *Disadvantages* of using an emergency room include lack of continuity in medical care; lack of medical monitoring; and high cost. Emergency rooms are not meant for delivery of routine preventive health care or treatment of minor health problems. Caregivers should be instructed to contact the child’s primary care provider/medical home for guidance when in doubt as to whether a health condition warrants use of the emergency room. In many cases, the primary care provider can give health instruction over the telephone, or direct the caregiver to bring the child in for an office evaluation instead of an emergency room visit.

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<sup>7</sup> 18 NYCRR 507.1(c)(4).

<sup>8</sup> 18 NYCRR 441.22(j)(i)(ii) and (iii).

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### 4 Health/Mental Health Training

It is critical that caregivers receive ongoing training on health and mental health issues of children in foster care. To be effective in managing these issues, caregivers should have basic information on health care (including preventive health) and detailed information on the particular condition or illness of children in their care. Training on attitudes and skills related to health and mental health issues is very important.

#### Training Topics

Health education and training for caregivers should cover the following topics:

- Overview of health care for children in foster care, medical home, preventive health services, treatment plans, and childhood health requirements and time frames (e.g., immunization schedule).
- Wellness awareness, nutrition, and physical fitness.
- Common health problems and dealing with emergencies.
- Proper administration and documentation of medication and taking of a child's temperature (written and/or skill exam is recommended).
- Family planning, sexuality education, and reproductive health services.
- Detailed information on conditions that may be seen in children in care (e.g., head lice, mental health disorders).
- HIV/AIDS education.
- Infection control and universal precautions (written and/or skill exam is recommended).

When a child or adolescent in foster care has a serious medical condition, the child, the foster parents, and the birth parents should receive additional education, training, and support resources as appropriate. For example, foster parents caring for children who need to take medication in school should know how to coordinate with the school.



#### Health Care Coordination Activities

Caregivers should also be familiar with the school's exclusion policies on communicable diseases. A checklist for conditions that are contagious and require staying away from school would be helpful for foster parents. Check with the schools in the community to see if they provide a list of such conditions and illnesses to parents, what the rules are for returning the

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child to school, and opportunities for the child to continue studies with work sent home (*see Chapter 2, Preventive and Ongoing Health Care, section 8, Acute Illness and Injury/Emergency Care*).

Regarding behavioral and mental health issues, caregivers should learn how to recognize indicators of mental health problems. A majority of children in foster care have experienced trauma as a result of abuse, pervasive neglect, or witnessing violence. Caregivers need to understand what has happened to the children in their care, and provide a safe and supportive place for the child to heal and grow. Topics for training and education include:

- Child and adolescent development and behavior.
- Emotional effects of child abuse and neglect.
- Impact of domestic violence.
- Loss and separation.
- Providing trauma-informed care.
- Common mental health illnesses (e.g., depression, anxiety).
- Behavior management.
- Effects of alcohol and substance abuse.
- Medications and their side effects

In addition, training should give caregivers skills in crisis counseling that are appropriate to their role. In contacts with caregivers, emphasize the need to be sensitive to signs of emotional distress in children in care. Having such knowledge should help caregivers feel more confident in their role.

## Training Materials

To reinforce the skills and knowledge acquired in training and provide a ready reference, give foster parents written materials containing much of the information covered in training. Some agencies include tips on what to do in an emergency, how to handle common childhood illnesses, when to seek medical care, medication guides, and developmental charts. Any materials should be specific to infants, toddlers, young children and adolescents, and the health care setting in which the child will receive care. To track the child's growth and development, give foster parents developmental schedules and ask them to keep records of growth. Share materials with the child's birth parent or guardian as appropriate.

To follow up, as part of each home visit caseworkers should review key training concepts with foster parents and provide handouts and other materials received at any staff training sessions.

Tracking attendance and completion of training is necessary to determine whether foster parents have met the training requirements. Tracking is also a useful tool to assess progress in acquiring skills and knowledge of health topics. Consider asking foster parents to sign a form indicating their acceptance and understanding after they have received training on health issues. Copies of any tracking forms should be placed in the foster parent's recertification record.

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### Sources of Training

Training for caregivers on health and mental health issues can come from a variety of sources. For example, in-service training sessions for foster parents, arranged or conducted by staff, may spotlight guest speakers from community hospitals, schools, and local police and fire departments.

Existing programs can be identified through the following:

- MAPP/GPS
- Early Intervention Program
- Public (County) Health Department
- Planned Parenthood
- Local hospitals
- Universities
- School district
- State-sponsored training

**MAPP/GPS.** The Model Approach to Partnerships in Parenting/Group Preparation and Selection (MAPP/GPS) Pre-Certification Training Program consists of three-hour sessions each week for 10 weeks. MAPP/GPS provides a model for working toward partnerships in parenting among agencies, foster parents, adoptive parents, and birth families. This approach to foster parenting encourages open communication and trust among foster families, adoptive families, birth families, and casework staff. A primary goal of the training sessions is to articulate ways to ensure that children's needs for safety and nurturing are met. Depending on the needs of the children who come into care, MAPP training also covers parenting issues for children with specific disabilities and conditions.

In addition to the MAPP/GPS training provided to new and prospective foster parents, a Mini-MAPP training program (15 hours) is available (and required by some agencies) for current foster parents.

**Compass Training.** This training, offered by the Center for Development of Human Services (CDHS), is offered at three levels for newly certified foster parents and covers topics of health and safety. Check with your agency staff development coordinator for arrangements to send foster parents to this training.

**Early Intervention Program.** When communication disorders or other developmental problems have been identified through the New York State Department of Health's Early Intervention Program, part of treatment includes parent training programs in which the parent (caregiver) receives instruction in the treatment approach and specific goals of the intervention, demonstrations of intervention techniques, feedback on their use of such techniques, and ways to adapt intervention methods to their foster child's needs. This training is strongly encouraged when the foster parent is the primary caregiver for a child with communication disorders. Include the birth parents or guardian whenever possible.

**Public Health Department.** It is recommended that agencies bring in trainers or speakers from the local health department on a regular basis. After foster parents have completed MAPP training, survey them to find out what health and mental health topics they need or would like to be covered.

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The public health department is also the source of information and training on the Early Intervention Program.

**Planned Parenthood.** Training is available on issues of sexuality and family planning (e.g., contraception, emergency contraception, pregnancy prevention).

**Local Hospitals and Universities.** Many hospitals offer patient education programs, some of which may be relevant for foster parents caring for children with chronic illness or conditions (e.g., cardiac care). Medical universities often provide classes for the public on special topics.

**School District.** For training and information on preschool special education services, contact the local school district. Caregivers and birth parents, if possible, should attend these sessions.

**State-sponsored Training.** The New York State Office of Children and Family Services provides training for staff and foster parents through contracts with various trainers. Check with the staff development coordinator in your local district.

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### 5 Foster Parent Associations and Support Groups

An additional source of support for foster parents is other foster parents. Some agencies help create foster parent support groups that engage in discussions of common concerns and strengths as well as family activities. In some districts, experienced foster parents serve as mentors with new foster parents. Through groups or one-on-one, foster parents should feel free to call another foster parent and talk over a situation.



#### Health Care Coordination Activities

Make foster parent meetings as convenient as possible for caregivers. Suggestions include:

- Schedule meetings in the evenings.
- Provide child care.
- Ask for input from foster parents on topics.
- Invite speakers from the community with expertise in topics requested.
- Consider having an experienced foster parent facilitate meetings.
- Provide handouts on resources (e.g., list of community health care providers, pharmacies, services for special needs).

Some districts have foster parent associations or local chapters of the New York State Foster and Adoptive Parent Association (NYSFAPA). Foster parent associations provide valuable support and resources for foster parents.

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## 6 Resources

### Statewide Organizations for Foster and Adoptive Parents

#### **New York State Citizens' Coalition for Children, Inc.**

410 East Upland Rd.

Ithaca, NY 14850

607-272-0034

607-272-0035 fax

office@nysccc.org

<http://www.nysccc.org>

#### **New York State Foster and Adoptive Parents Association, Inc.**

92-31 Union Hall St.

P.O. Box 120151

St. Albans, NY 11412

718-725-3657 or 718-725-2103

Fax: 718-725-2104

### Treatment of Children with Mental Disorders

<http://www.omh.state.ny.us/omhweb/booklets/pdf/children.pdf>

This June 2008 publication of the Office of Mental Health is appropriate for foster parents. The booklet offers answers to frequently asked questions regarding the treatment of children with mental disorders, descriptions of classes of medication, a chart of medications most commonly prescribed for children, and contact information for OMH regional offices.

### Emergency Fact Sheet

See the next page for a sample Emergency Fact Sheet for foster parents.

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### Emergency Fact Sheet

*Source: Association to Benefit Children, Variety Cody Gifford House*

#### **What Is Considered an Emergency?**

1. A child who is having difficulty breathing (like asthma or choking).
2. Child's color doesn't look right (blue tinged or very pale).
3. Any head injury. Observe the child for the first 12 hours after a bump on the head. During this time, if the child is dizzy, or fainted, or is too sleepy, or is difficult to wake up, or acts drunken or drowsy, or has a bad headache, or is vomiting – bring to the ER.
4. A deep cut that may need stitches after-hours when clinics and doctors' offices are closed. [In the meantime, gently clean the wound with large amounts of lukewarm running water (use Betadine if you have it), and wrap or cover with a clean bandage or cloth. If bleeding is very heavy apply pressure – but not too hard!]
5. Seizures (also called convulsions or fits). A prolonged seizure can be life threatening. (In the meantime, remove all obstacles in the area around the child and provide cushioning under the head if he/she is banging it on a hard floor. **DO NOT** try to stop movements, **BUT** turn to side if vomiting or drooling heavily).
6. Any heavy bleeding that cannot be stopped within five minutes.
7. An accident or injury where you think a serious injury may have occurred (e.g., depending on the force, direction, or location of the injury).
8. A high fever and it is after-hours when your doctor's office or clinic is closed (or when your doctor/ clinic instructed you to go to the ER).
9. Excessive diarrhea or vomiting. Infants and very young children dehydrate quickly, so this may be a serious emergency. The child may require intravenous fluids.
10. Any eye injury. Do not apply pressure or put anything into the eye.

**Note:** If your child's eye is swollen and/or crusty from allergies or “pink eye” (conjunctivitis), the child should be seen at an office or clinic as soon as possible. It is not considered an emergency. In the meantime, it may be contagious from one eye to the other – or to someone else. So be careful not to share towels or clean both eyes with the same cloth.

**Note:** If the child eats or drinks something that maybe poisonous (e.g., medicine, cleaning products, or plants), call Poison Control (1-800-222-1222) and get advice on what to do.

**Remember:** Foster parents cannot consent to treatment. Call your caseworker as soon as you get to the emergency room.

Give all of the paper work and instructions that you received from the ER to your caseworker or health care coordinator.

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## *Appendix A*

# Forms and Websites

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### Forms

The following sample forms are presented in the order in which they are referenced in the manual.

#### ■ Chapter 1, Initial Evaluation of Child's Health

- **Admission Screening Interview:** This screening interview tool was designed for youth at the time of initial placement into OCFS Division of Juvenile Justice and Opportunities for Youth facilities. It may be adapted for use with children being placed in foster care..... 5
- **Health History Interview With Family:** This form may be used at any opportunity of contact with the child's family to record and update the child's health history. The Birth Family's Health History list corresponds with the Conditions list in the CONNECTIONS Bio Family Health tab. The form assists in collecting critical information for health services providers and for the child's medical record..... 7
- **Medical Review of Systems:** The Medical Review of Systems form can guide staff in obtaining a more thorough health history on the child from a family member or caregiver. It includes observations of the child's condition and behavior that may not be typically gathered by the health care practitioner but could prove very helpful. .... 13

#### ■ Chapter 3, Special Health Care Services

- **Family Planning Notice:** This sample letter is used to inform youth age 12 and older of the availability of social, educational, and medical family planning services. .... 17

#### ■ Chapter 4, Health Care Coordination

- **Health Care Coordination and Treatment Plan:** This form is used to record findings from the initial screening as well as the five assessments comprising the comprehensive health evaluation, during the first 30 to 45 days of the child's placement. .... 19
- **Health Discharge Summary:** This sample health discharge summary form may be used to record health activities when a child is discharged from foster care. .... 21

#### ■ Chapter 5, Medication Administration and Management

- **Medication Log for Caregivers:** This form may be used to assist the caregiver in documenting the administration of medication. Both a blank form for replication and a sample form with entries displayed are included. .... 23
- **Informed Consent for Psychiatric Medication – Children in Foster Care:** This form provides information that supports the informed consent process and includes the medication monitoring plan and contact numbers. Use a separate form for each medication, and attach the drug information sheet. .... 27

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- **Guidelines for Voluntary Agencies Regarding Informed Medical Consent for Behavioral/Psychotropic Medication and Informed Medical Consent for Behavioral/Psychotropic Medication:** These Guidelines and accompanying Consent Form were developed by a group of local commissioners and voluntary agency directors to standardize and facilitate the communication process between them in regard to consent for psychiatric medications. The form is used when the agency has been unable to obtain an informed consent from the parent/guardian and is requesting consent from the LDSS commissioner. .... 29
- **Chapter 6, Medical Consents**
  - **Informed Consent to Perform HIV Testing (DOH-2556 and 2556i):** For a copy of the form, go to the NYS Department of Health website, [www.health.state.ny.us](http://www.health.state.ny.us), and click on HIV/AIDS. . This form is available in several languages.  
<http://www.health.state.ny.us/diseases/aids/forms/informedconsent> ..... 33
- **Chapter 7, Confidentiality of Health Information**
  - **Authorization for Release of Confidential HIV Related Information (DOH-2557, Rev. 8/05):** For a copy of the form, go to the NYS Department of Health website. This form is also available in Spanish.  
<http://www.health.state.ny.us/diseases/aids/forms/informedconsent> ..... 37
- **Chapter 8, Maintaining Health Records**
  - **Health History Interview With Family** (*see description under Chapter 1, p. Appendix A-2*)
- **Chapter 9, Working With Community Health Care Providers**
  - **Health Care Provider Visit Record:** This summary visit record form provides an efficient way for medical providers to document the findings of the health service visit. The person accompanying the child to the visit requests that the form is completed before leaving the provider’s office, and it is then placed in the child’s agency health file. .... 41
  - **Mental Health Care Provider Visit Record:** This summary visit record form may be used for visits to mental health providers. .... 43
  - **Service Agreement:** This is a suggested model for a service agreement, which agencies may adapt for their use. .... 45
  - **Application for Discrete Medicaid Rate:** This five-page form guides voluntary agencies in the development of an application for a Medicaid per diem rate for a special population. The accompanying two-page document describes the approval process..... 47

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## SAMPLE ADMISSION SCREENING INTERVIEW

*Source: NYS Office of Children and Family Services, Form DFY-1448*

The purpose of this interview is to determine if a youth at admission has any health problems that require immediate medical attention. A "Yes" answer to any of the following questions must result in consultation with a physician, registered nurse, physician's assistant or, in the absence of medical staff, the facility director. These professionals shall determine if the youth must be personally seen by a medical professional before being placed in the general facility population.

Youth Name	Case Number	Date of Birth
		M____D____Y____
A. MEDICAL HISTORY		
1. Does the youth complain of pain or believe he/she is sick or in need of mental health or dental services?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
2. Is the youth being treated for a medical, dental, or mental health problem?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
3. Does the youth believe he/she has a sexually transmitted disease? Any communicable disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
4. Does the youth report any past hospitalizations for medical or mental health problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
5. Does the youth report any past history of suicidal thoughts or gestures?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
6. If the youth is a girl, does she believe she is pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	How long does she believe she has been pregnant? _____ # of Months Is she under medical care for the pregnancy? No Yes
7. Does the youth take prescription or non-prescription medication(s)?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes → Attach sheet if more than one.	Name of Medication: Dosage: Frequency of Administration: Date and Time of Last Dose:
8. Does the youth have head lice?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	What treatment was done?
9. Does the youth have food or medication allergies?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
10. Does the youth have any dietary requirements?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
11. Has the youth taken any street drugs or used alcohol within the past 24 hours?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Name of Drug: Amount Used:                      Mode of Use: Frequency Used: Date/Time of Last Use: Any Problems Indicated:

Sample Admission Screening Interview, continued

<b>B. OBSERVATIONS</b>	
1. <b>Youth Behavior:</b> Is the youth calm, frightened, intimidated, sweating, shaking, etc.?	Explain:
2. <b>General Appearance:</b> Is the youth clean, appropriately dressed, polite, cared for, etc.?	Explain:
3. <b>Mental Status:</b> Is the youth aware of his/her surroundings, under the influence of drugs or alcohol, exhibiting bizarre thoughts or speech, expressing suicidal or homicidal thoughts, able to communicate needs, etc.?	Explain:
4. <b>Physical Condition:</b> Does the youth exhibit any trauma markings, bruises, cuts, needle marks, abnormal gait, or other signs of recent injury?	Explain:
<b>NOTE:</b> If trauma markings are evident, take or cause to be taken, color photographs of visible or reported trauma. All reports of alleged abuse or maltreatment must be reported to the State Central Register of Child Abuse and Maltreatment.	
<b>C. MEDICAL DISPOSITION</b>	
Upon completion of your screening, a decision must be made as to where the youth will be placed:	Specify
<input type="checkbox"/> General Population	
<input type="checkbox"/> General Population with Restrictions	
<input type="checkbox"/> General Population with Referral for Health Services	
<input type="checkbox"/> Immediate Referral for Emergency Treatment	
<b>D. INTERVIEWER INFORMATION</b>	
Name	
Title	
Signature	
Date	
Time	

## SAMPLE HEALTH HISTORY INTERVIEW WITH FAMILY

Name of Child:	Date of Birth: M___D___Y___
Birth Mother's Name:	Date of Birth: M___D___Y___
Is mother deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, cause of death:</i>	Date of Death: M___D___Y___
Birth Father's Name:	Date of Birth: M___D___Y___
Is father deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, cause of death:</i>	Date of Death: M___D___Y___
<b>BIRTH FAMILY'S HEALTH HISTORY</b>	
Does the parent, a biological relative of the parent, or a biological sibling of the child in foster care, have a history of the following? If yes, check in the box, and insert family member's relationship to the child.	
<b>Health History of Parent, Biological Relative, Biological Sibling</b>	<b>Family Member's Relationship to Child</b>
<input type="checkbox"/> Alcohol Abuse/Dependence	
<input type="checkbox"/> Allergies ( <i>specify</i> )	
<input type="checkbox"/> Aneurysm	
<input type="checkbox"/> Asperger's Disorder	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Autism	
<input type="checkbox"/> Blind/Visually Impaired	
<input type="checkbox"/> Cancer ( <i>specify</i> )	
<input type="checkbox"/> Celiac Disease	
<input type="checkbox"/> Cerebral Palsy	
<input type="checkbox"/> Cleft Lip or Palate	
<input type="checkbox"/> Cystic Fibrosis	
<input type="checkbox"/> Deaf/Hearing Impaired	
<input type="checkbox"/> Diabetes Type I	
<input type="checkbox"/> Diabetes Type II	
<input type="checkbox"/> Down Syndrome	
<input type="checkbox"/> Dwarfism	
<input type="checkbox"/> Eczema	
<input type="checkbox"/> Emphysema	
<input type="checkbox"/> Epilepsy/Seizure Disorder	
<input type="checkbox"/> Fragile X Syndrome	
<input type="checkbox"/> Gingivitis (periodontal disease)	
<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Hemophilia	
<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Hypertension (high blood pressure)	
<input type="checkbox"/> Kidney Disease	

Sample Health History Interview with Family, continued

Health History of Parent, Biological Relative, Biological Sibling	Family Member Name/ Relationship to Child
<input type="checkbox"/> Learning Disabled ( <i>specify</i> )	
<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Lupus	
<input type="checkbox"/> Mental Illness ( <i>specify</i> )	
<input type="checkbox"/> Mental Retardation	
<input type="checkbox"/> Migraines	
<input type="checkbox"/> Motor Delay/Impairment	
<input type="checkbox"/> Multiple Sclerosis	
<input type="checkbox"/> Muscular Dystrophy	
<input type="checkbox"/> Narcolepsy	
<input type="checkbox"/> Neurofibromatosis	
<input type="checkbox"/> Neurological Impairment	
<input type="checkbox"/> Obesity	
<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Pervasive Developmental Disorder	
<input type="checkbox"/> Prader-Willi Syndrome	
<input type="checkbox"/> Scleroderma	
<input type="checkbox"/> Scoliosis	
<input type="checkbox"/> Seizure Disorder/Epilepsy	
<input type="checkbox"/> Sensory Impairment	
<input type="checkbox"/> Sickle Cell Disease/Trait	
<input type="checkbox"/> Social/Emotional Delay/Impairment	
<input type="checkbox"/> Speech/Language Delay/Impairment	
<input type="checkbox"/> Spina Bifida	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Substance Abuse/Dependence	
<input type="checkbox"/> Tay-Sachs Disease	
<input type="checkbox"/> Tourette's Disorder/Syndrome	
<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Ulcer	
<input type="checkbox"/> Other ( <i>specify</i> )	



<b>CHILD'S HEALTH HISTORY</b>						
<b>Allergies [include symptom(s) and severity]:</b>						
Food	Environmental			Medication		
<b>Durable Medical Equipment (eyeglasses, hearing aids, etc.)::</b>						
<b>Immunization History (If documentation is presented):</b>						
Type	Date	Date	Date	Date	Date	Date
Hepatitis A			X	X	X	
Hepatitis B				X	X	
DTaP (diphtheria, tetanus, pertussis)						
Hib (haemophilus influenza type b)						X
MMR (measles, mumps, rubella)			X	X	X	
Varicella (chicken pox)			X	X	X	
IPV (polio)						X
PCV7 (pneumococcal disease)						X
Rotavirus (gastroenteritis)				X	X	
Tdap (tetanus, diphtheria, pertussis)		X	X	X	X	
MCV4 (meningococcal disease)		X	X	X	X	
HPV (human papilloma virus)				X	X	
Influenza						
Other, specify						
<b>Medications</b>						
Name of Medication	Date Prescribed	Dosage and Frequency	Condition Treated	Prescribing Provider		

*Sample Health History Interview with Family, continued*

Health Providers and Medical Record Contacts (list Primary Care Provider first)		
Professional (MD, PA, etc.)	Address	Phone
<b>Sleep habits:</b> <input type="checkbox"/> normal <input type="checkbox"/> up & down all night <input type="checkbox"/> early awakening (e.g., 4 am) <input type="checkbox"/> trouble falling asleep <input type="checkbox"/> night terrors <input type="checkbox"/> bed-wetting or soiling	<b>Diet:</b> <input type="checkbox"/> regular <input type="checkbox"/> special ( <i>If special, explain _____</i> )  Likes:  Dislikes:	
<b>Medical History</b> (include chronic medical conditions, serious injuries, surgeries, hospitalizations, and dates):          		
<b>Current and recent health concerns:</b>          		
<b>Behavioral concerns</b> (include sexual behavior and substance use):          		



## SAMPLE MEDICAL REVIEW OF SYSTEMS

Source: Jewish Child Care Association

### SKIN

- |   |   |                                |  |
|---|---|--------------------------------|--|
| <input type="checkbox"/> No difficulty      | <input type="checkbox"/> Eczema             | <input type="checkbox"/> Acne  | <input type="checkbox"/> Scars         |
| <input type="checkbox"/> Tattoos            | <input type="checkbox"/> Birthmarks         | <input type="checkbox"/> Burns | <input type="checkbox"/> Warts/lesions |
| <input type="checkbox"/> Excessive bruising | <input type="checkbox"/> Hair/nail problems |                                |  |

**Comments:**

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### NEUROLOGICAL (nerves and brain)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> No difficulty | <input type="checkbox"/> History of head injury       | <input type="checkbox"/> Concussion            |
| <input type="checkbox"/> Dizziness     | <input type="checkbox"/> Loss of consciousness        | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Weakness      | <input type="checkbox"/> Abnormal movements           | <input type="checkbox"/> Tics or vocalizations |
| <input type="checkbox"/> Fainting      | <input type="checkbox"/> Frequent/recurrent headaches |  |

**Comments:**

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### VISUAL (eyes and vision)

- |   |   |
|---|---|
| <input type="checkbox"/> No difficulty              | <input type="checkbox"/> Eyeglasses                                   |
| <input type="checkbox"/> Crossed eyes or "lazy eye" | <input type="checkbox"/> Problems (pain, redness, itchiness, blurred) |
| <input type="checkbox"/> Corrective surgery         | <input type="checkbox"/> Injuries                                     |

**Comments:**

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### AUDITORY (ears and hearing)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> No difficulty   | <input type="checkbox"/> Chronic infections                   | <input type="checkbox"/> Surgery (tubes) |
| <input type="checkbox"/> Hearing devices | <input type="checkbox"/> Other (ringing in ears/hearing loss) |  |

**Comments:**

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### NOSE AND SINUSES

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> No difficulty             | <input type="checkbox"/> Nosebleeds               | <input type="checkbox"/> Cold/heat induced problems |
| <input type="checkbox"/> Nasal discharge           | <input type="checkbox"/> Chronic nasal stuffiness | <input type="checkbox"/> Frequent sinus infections  |
| <input type="checkbox"/> Nose injuries (fractures) |   |   |

**Comments:**

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**MOUTH AND THROAT**

- No difficulty
- Recurrent tonsillitis
- Hoarseness
- Tonsils and/or adenoids removed

**Comments:**

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**DENTAL**

- No difficulty
- Missing teeth
- Chipped teeth
- Orthodontia
- Toothache
- Cavities
- Painful swollen gums

**Comments:**

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**RESPIRATORY (breathing and lungs)**

- No difficulty
- History of tuberculosis or positive TB test
- Smoking
- Frequent colds
- Chronic cough
- Recurrent pneumonia
- Asthma: *If child has asthma, ask the following questions:*
  - \_\_\_\_\_ Age of onset
  - \_\_\_\_\_ Last episode
  - \_\_\_\_\_ Medication
  - Triggers:*  Physical/cold
  - Dust
  - Pets
  - Feathers
  - Exercise induced
  - Emotionally induced
  - Illness induced

**Comments:**

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**CARDIOVASCULAR (heart, arteries and veins)**

- No difficulty
- Heart murmur
- Heart surgery
- Palpitations
- Shortness of breath
- High blood pressure
- Family history of heart attack or stroke before age 40

**Comments:**

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**NUTRITIONAL (food and diet)**

- Vegetarian
- Eating Disorder
- Food allergies
- Overweight
- Underweight
- Daily milk/formula intake \_\_\_\_\_ oz.
- Supplements \_\_\_\_\_

**Comments:**

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Medical Review of Systems, continued

**GASTROINTESTINAL (stomach and digestion)**

- No difficulty
- Constipation
- Diarrhea
- Vomiting
- Indigestion
- Lactose intolerance
- Food intolerance
- Rectal bleeding
- Ulcer
- Anal itching
- Encopresis/soiling
- Recent weight loss/gain
- Describe appetite \_\_\_\_\_

**Comments:**

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**URINARY (kidneys and urine)**

- No difficulty
- Bed-wetting
- Day-wetting
- Difficulty voiding
- Bladder/kidney infections
- Frequent urination

**Comments:**

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**ENDOCRINE (glands and hormones)**

- No difficulty
- Does not tolerate heat well
- Does not tolerate cold well
- Jittery
- Poor growth
- Thirsty all the time

**Comments:**

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**MUSCULOSKELETAL (muscles and bones)**

- No difficulty
- Scoliosis
- Joint/muscle pain/swelling
- Congenital deformities (toes, fingers, etc.)
- Back pain
- Sports injuries (fractures)
- Gait abnormalities
- Frequent broken bones ( more than 3 times)

**Comments:**

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**SLEEP**

- No difficulty
- Sleep pattern difficulties
- Night walking
- Nightmares
- Difficulty falling asleep
- Solutions \_\_\_\_\_

**Comments:**

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**FEMALE GENITAL SEXUAL HISTORY**

- Date menarche began M\_\_D\_\_Y\_\_
- Average length of period \_\_\_\_ Days
- Breast lumps       Nipple discharge
- Last GYN/Breast exam M\_\_D\_\_Y\_\_
- Number of pregnancies \_\_\_\_
- Number of miscarriages \_\_\_\_
- Previous HIV testing M\_\_D\_\_Y\_\_
- Last menstrual period M\_\_D\_\_Y\_\_
- Menstrual cramps
- Vaginal discharge
- STDs (type\_\_\_\_\_)
- Number of abortions \_\_\_\_
- Number of live births \_\_\_\_
- Contraception\_\_\_\_\_

**Comments:**

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**MALE GENITAL SEXUAL HISTORY**

- Last testicular exam M\_\_D\_\_Y\_\_
- Hernia
- Penile discharge
- STDs (type\_\_\_\_\_)
- Contraception\_\_\_\_\_
- Pain in penis/testicles
- Penile sores/lesions
- Lumps on or near testicles
- Previous HIV testing M\_\_D\_\_Y\_\_

**Comments:**

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**HEMATOLOGY (blood)**

- No difficulty     Anemia     Bleeding problems
- Abnormal lumps or bumps (enlarged lymph nodes)

**Comments:**

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**SEXUAL ABUSE SCREEN**

- Has the child ever had an unwanted sexual experience?  Yes     No
- Sexual Activity:     Inactive       Single partner     Multiple partners
- Same sex       Opposite sex

**Comments:**

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**SUBSTANCE ABUSE SCREEN**

- History of use:     Cigarettes     Marijuana     Alcohol     Other drugs\_\_\_\_\_

**Comments:**

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## SAMPLE FAMILY PLANNING NOTICE

*Source: Association to Benefit Children, Variety Cody Gifford House*

Date:

Dear:

I am writing you this letter to encourage you to set up an appointment with me in order to discuss **Family Planning Services and Human Sexuality**. I realize that not all adolescents are sexually active. However, even if you are not sexually active, you are entitled to have this information and to have someone that you can talk to about these issues, privately.

If, for some reason, you are unwilling to do so, I am including a packet of information on places for you to go in order to receive these services. This packet also includes reading material related to human sexuality and safety. If you decide to use any of the services offered, please let me know if it was helpful so that I can recommend it to other youth – or not.

Don't be surprised if you receive this same request and the same packet every six months. We would rather be persistent than forgetful when it comes to your health and safety.

Sincerely,

Your foster care nurse



## SAMPLE HEALTH CARE COORDINATION & TREATMENT PLAN (30-45 Days)

*Source: Kinship Family and Youth Services*

Name of Child:		Date of Birth: M ___ D ___ Y ___	Date Placed: M ___ D ___ Y ___
<b>INITIAL SCREENING (24 HOURS)</b>			
Appt. Date: M ___ D ___ Y ___		Where/With Whom	
Date Completed: M ___ D ___ Y ___			
Follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: M ___ D ___ Y ___		Instructions	
<b>COMPREHENSIVE HEALTH EVALUATION</b>			
<b>Medical Assessment</b> (includes physical exam, vision, hearing, other screening tests)			
Appt. Date: M ___ D ___ Y ___		Where/With Whom	
Date Completed: M ___ D ___ Y ___			
Follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: M ___ D ___ Y ___		Instructions	
<b>Dental Assessment</b>			
Appt. Date: M ___ D ___ Y ___		Where/With Whom	
Date Completed: M ___ D ___ Y ___			
Follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: M ___ D ___ Y ___		Instructions	
<b>Mental Health Assessment</b>			
Appt. Date: M ___ D ___ Y ___		Where/With Whom	
Date Completed: M ___ D ___ Y ___			
Follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: M ___ D ___ Y ___		Instructions	
<b>Developmental Assessment</b>			
Appt. Date: M ___ D ___ Y ___		Where/With Whom	
Date Completed: M ___ D ___ Y ___			
Follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: M ___ D ___ Y ___		Instructions	
<b>Substance Abuse Assessment</b>			
Appt. Date: M ___ D ___ Y ___		Where/With Whom	
Date Completed: M ___ D ___ Y ___			
Follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: M ___ D ___ Y ___		Instructions	
<b>HEALTH CONCERNS</b>			
<b>Physical</b>			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___
<b>Dental</b>			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___

*Sample Health Care Coordination & Treatment Plan (30-45 Days), continued*

<b>Developmental</b>			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___ M ___ D ___ Y ___ M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___ M ___ D ___ Y ___
<b>Substance Abuse</b>			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___ M ___ D ___ Y ___ M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___ M ___ D ___ Y ___
<b>Medications</b>			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___ M ___ D ___ Y ___ M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___ M ___ D ___ Y ___
<b>Nutrition</b>			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___ M ___ D ___ Y ___ M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___ M ___ D ___ Y ___
<b>Sexuality Education</b>			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___ M ___ D ___ Y ___ M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___ M ___ D ___ Y ___
<b>Other</b>			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___ M ___ D ___ Y ___ M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___ M ___ D ___ Y ___

SAMPLE HEALTH DISCHARGE SUMMARY

Name of Child:	Date of Birth: M___D___Y___
Date Placed with Agency: M___D___Y___	Date of Discharge: M___D___Y___
<b>PRIMARY CARE PHYSICIAN</b>	
Name:	
Address:	
Phone:	
Last Seen: M___D___Y___	Reason:
Findings:	
<b>SPECIALISTS</b>	
<p><b>Dentist:</b> Address/Phone:</p> <p>Last Seen: M___D___Y___ Reason: Findings: Next Appointment: M___D___Y___</p> <p><b>Other Specialist:</b> Address/Phone:</p> <p>Last Seen: M___D___Y___ Reason: Findings: Next Appointment: M___D___Y___</p> <p><b>Other Specialist:</b> Address/Phone:</p> <p>Last Seen: M___D___Y___ Reason: Findings: Next Appointment: M___D___Y___</p>	<p><b>Mental Health Provider:</b> Address/Phone:</p> <p>Last Seen: M___D___Y___ Reason: Findings: Next Appointment: M___D___Y___</p> <p><b>Other Specialist:</b> Address/Phone:</p> <p>Last Seen: M___D___Y___ Reason: Findings: Next Appointment: M___D___Y___</p> <p><b>Other Specialist:</b> Address/Phone:</p> <p>Last Seen: M___D___Y___ Reason: Findings: Next Appointment: M___D___Y___</p>

Sample Health Discharge Summary, continued

OUTSTANDING MEDICAL ISSUES			
Explain:			
MEDICATIONS AT DISCHARGE			
Name	Dosage	Purpose	Prescribed By
INSURANCE			
Insurance coverage after discharge:			
SIGNATURES			
Testament	<input type="checkbox"/> have received a copy of the Health Discharge Summary.		
Name of Parent/Guardian			
Signature of Parent/Guardian			
Date			





Medication Log Sample		Child's name: Tiffany Iminicare		Initials Code		Primary Care (Medical Home) Provider: Dr. Nightingale																											
		Date	Month: November	Initials	Name	Address: 206 Main St., Anytown, NY 10001	Phone number: (123) 456-7890																										
Medication name, prescriber, dosage, route	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
One-a-Day vitamins (Dr. Nightingale) Take 1 by mouth each morning	8:00 AM	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	
Ritalin LA 20 mg. (Dr. Thompson) Take 1 by mouth each morning	8:00 AM	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	SC	
Amoxil, 400 mg. (Dr. Nightingale) Take by mouth twice a day	8:00 AM									SC																							
Ibuprofen, 200 mg. (Dr. Nightingale) Take 1 tablet every 4 hours as needed for pain	8:00 AM									RC																							
	12:00 PM									SC																							
	4:00 PM									RC																							
	8:00 PM									RC																							
<b>Directions:</b> Enter one medication per box in the left column. Enter the time of the day that medication is to be taken. Put a checkmark or initial in the box each time the medication is given. Add comments (for example: child refused, child became sleepy) below.																																	

\*For example: fever broke, fell asleep, became agitated.







## **GUIDELINES FOR VOLUNTARY AGENCIES REGARDING INFORMED MEDICAL CONSENT FOR BEHAVIORAL/PsYCHOTROPIC MEDICATION**

**Purpose:** The purpose of these guidelines is to describe when and how to obtain informed medical consent for behavioral/psychotropic medication recommended for children in foster care following admission to a voluntary agency.

For detailed information about medications and the informed medical consent process, see the NYS Office of Children and Family Services manual “Working Together: Health Services for Children in Foster Care,” Chapters Five and Six. The manual is available on the OCFS website at [http://www.ocfs.state.ny.us/main/sppd/health\\_services/manual.asp](http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp). Refer also to the Informational Letter 08-OCFS-INF-02 “The Use of Psychiatric Medications for Children and Youth in Placement; Authority to Consent to Medical Care” at <http://www.ocfs.state.ny.us/main/policies/external/>.

### **Obtaining Informed Medical Consent For Behavioral/Psychotropic Medication From the Parent/Legal Guardian:**

- Voluntary agency staff are expected to enable parents/legal guardians who maintain legal guardianship to have the opportunity to provide informed medical consent; for example, encouraging their participation in medication review meetings and accompanying their children to medical appointments.
- If the parent/legal guardian who maintains legal guardianship is not present when a recommendation is made to begin or to change a prescribed psychotropic/behavioral medication, agency staff will contact the parent/legal guardian via phone calls, home visits, and letters to request their providing informed medical consent. Assistance from the LDSS caseworker may be requested as needed. This form is to be used when there is a new medication prescribed or a change that is outside the parameters of the previously approved dosage range, or when a child/youth is surrendered or freed for adoption.
- When the parent/legal guardian who maintains legal guardianship signs the voluntary agency’s informed medical consent form, agency staff will document, in a progress note in the CONNECTIONS case management system, the recommendation of the prescribing practitioner and that parental/legal guardian informed medical consent has been obtained.

### **When To Obtain Informed Medical Consent For Behavioral/Psychotropic Medication From the Local Department Of Social Services:**

**Note:** The local district of social services (LDSS) is not authorized by NY State regulation to sign consents for PINS and JD youth or children placed in foster care by voluntary agreement.

When a child in foster care is freed for adoption, either through surrender or termination of parental rights, the LDSS or voluntary agency with **guardianship** has full authority to consent to any medical care or procedure. LDSS is authorized to sign consents for children removed under Article 10 (abuse or neglect) or placed by a court in the custody of the LDSS under Article 10.

- When a parent/legal guardian who maintains legal guardianship **cannot be contacted** or refuses to consent, the voluntary agency may seek informed medical consent from the LDSS. Agency staff will document, in a progress note in the CONNECTIONS case management

system, the recommendation of the prescribing practitioner and that parental/legal guardian informed medical consent has not been obtained.

- In the event a parent/legal guardian rescinds their consent, or their **right to provide informed medical consent is surrendered or terminated**, **AND** the parent/legal guardian had previously provided informed medical consent for behavioral/psychotropic medication, the voluntary agency must request *new* informed medical consent from LDSS for any behavioral/psychotropic medication the child is currently prescribed.

### **How To Obtain Informed Medical Consent For Behavioral/Psychotropic Medication From the Local Department Of Social Services:**

A specific form has been designed to facilitate communication between voluntary agencies and local departments of social services when informed medical consent for behavioral/psychotropic medication is requested of them. Called the ***Informed Medical Consent For Behavioral/Psychotropic Medication\**** form, it is a tool to provide comprehensive information to the LDSS.

- Voluntary agency staff will forward the completed ***Informed Medical Consent For Behavioral/Psychotropic Medication\**** form, with all accompanying documentation, to the LDSS caseworker. The information will be presented by LDSS staff to the Commissioner of Social Services or his/her designee for a decision. The supporting documentation will be maintained in the LDSS case file. The LDSS will respond to the voluntary agency's request in a timely manner.
- In the event a child is justifiably **absent** from the voluntary agency (e.g., psychiatrically hospitalized, medically hospitalized, remanded or detained) **and** has not been discharged from the agency; **AND** the LDSS provides informed medical consent for a *new* behavioral/psychotropic medication, using the ***Informed Medical Consent For Behavioral/Psychotropic Medication\**** form, LDSS staff are responsible for providing to the voluntary agency a copy of the IMC prior to the child's return to them. LDSS staff will document, in a progress note in the CONNECTIONS case management system, the recommendation of the prescribing practitioner and that informed medical consent has been obtained and a copy given to the voluntary agency.
- In the event a child is **discharged** from a voluntary agency and is being placed in another voluntary agency, LDSS staff will arrange for copies of any ***Informed Medical Consent For Behavioral/Psychotropic Medication*** form currently in effect to be provided to the receiving voluntary agency.

**\*NOTE:** The ***Informed Medical Consent For Behavioral/Psychotropic Medication*** form is not required for non-behavioral/psychotropic medications or over the counter medications.

INFORMED MEDICAL CONSENT FOR  
BEHAVIORAL/PSYCHOTROPIC MEDICATION\*\*

Youth's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ CIN# \_\_\_\_\_  
(optional)  
Agency Name: \_\_\_\_\_ Date of Request: \_\_\_\_\_  
Contact: \_\_\_\_\_ Title/Role: \_\_\_\_\_  
PH: \_\_\_\_\_ FAX: \_\_\_\_\_

Prescribing Practitioner (print name and title) \_\_\_\_\_  
has recommended the above-named youth be placed on the following medication.

Medication: \_\_\_\_\_ With a dosage range of: \_\_\_\_\_

Check one of the following  New medication  Change to current medication  
 Change in guardianship

Diagnosis to be treated (not diagnostic code): \_\_\_\_\_

This is recommended because: \_\_\_\_\_

\_\_\_\_\_ **AND**

with the expected outcome of: \_\_\_\_\_

The following **required** documentation/information or summary report (including this information) is attached as indicated by the check marks:

- |  |   |
|--|---|
| <input type="checkbox"/> names of participants involved<br>in the decision-making              | <input type="checkbox"/> list of current medications  |
| <input type="checkbox"/> results of monitoring current medications<br>(including side effects) | <input type="checkbox"/> current findings<br>(i.e. practitioner's status report including<br>alternative approaches undertaken) |
| <input type="checkbox"/> patient education efforts   | <input type="checkbox"/> Drug Fact Detail Sheet   |

**Please note number of pages you are attaching to this form:** \_\_\_\_\_

Signature of **approval**: \_\_\_\_\_ Date signed: \_\_\_\_\_

Relationship to youth: \_\_\_\_\_ County: \_\_\_\_\_

*\*\*This form is to be used when there is a new medication prescribed or a change that is outside the parameters of the previously approved dosage range; or when a child/youth has been surrendered or freed for adoption .  
Use a separate form for each medication.*

Revised 11/21/05



## Important Phone Numbers

### New York State HIV/AIDS Hotlines (toll-free)

Call the Hotlines for information about HIV and AIDS and to find HIV testing sites

- 1-800-541-AIDS (2437) • English
- 1-800-233-SIDA (7432) • Spanish

### New York State TTY/TTD HIV/AIDS Information Line

- 1-212-925-9560

Voice callers use the NY relay:

- 711 or 1-800-421-1220 and ask the operator for: 1-212-925-9560

### New York State HIV/AIDS Counseling Hotline

- 1-800-872-2777

### NYSDOH Anonymous HIV Counseling and Testing Program

For HIV information, referrals, or information on how to get a free, anonymous HIV test, call the Anonymous HIV Counseling and Testing Programs.

- Albany Region 1-800-962-5065
- Buffalo Region 1-800-962-5064
- Nassau Region 1-800-462-6785
- New Rochelle Region 1-800-828-0064
- Queens Region 1-800-462-6785
- Rochester Region 1-800-962-5063
- Suffolk Region 1-800-462-6786
- Syracuse Region 1-800-562-9423

### NYCDOHMH HIV/AIDS Hotline: 1-800-TALK-HIV (1-800-825-5448)

### New York State PartNer Assistance Program: 1-800-541-AIDS

### New York City Contact Notification Assistance Program: 1-212-693-1419

### Confidentiality

- New York State Confidentiality Hotline 1-800-962-5065
- Legal Action Center 1-212-243-1313 or 1-800-223-4044

### Human Rights/Discrimination

- New York State Division of Human Rights 1-800-523-2437
- New York City Commission on Human Rights 1-212-306-7500

(00H-2556)(6/05) page 4 of 4

## Informed Consent to Perform HIV Testing

HIV testing is voluntary. Consent can be withdrawn at any time by informing your provider. Please read Parts A and B of this form, and sign at the bottom of Part B, if you understand the following information and want HIV testing.

HIV infection is a serious health concern. The New York State Department of Health recommends HIV testing. For pregnant women, the Department recommends HIV testing early in pregnancy and again late in pregnancy.

Part  
**A**

Except for expedited HIV testing on labor units, this form replaces other HIV testing consent forms as of June 1, 2005.

NOTE: this form is intended to be used in conjunction with DOH-2556, Part B.

(00H-2556)(6/05) page 1 of 4

### **HIV is the virus that causes AIDS.**

- HIV is passed from one person to another during unprotected sex (vaginal, anal or oral sex without a condom) with someone who has HIV.
- HIV is passed through contact with blood as in sharing needles (piercing, tattooing or injecting drugs of any kind) or sharing works with a person who has HIV.

### **The only way to know if you have HIV is to be tested.**

- HIV tests are safe. They involve collecting one or more specimens (blood, oral fluid, urine).
- Your counselor or doctor will explain your test result as well as any other tests you may need.

### **Your HIV test today includes:**

- A test to see if you have HIV infection (an antibody test or a test for the virus);
- if you are HIV positive, additional tests may include tests to:
  - help your doctor decide the best treatment for you.
  - help guide the health department with HIV prevention programs.

### **Several testing options are available.**

- You can choose to have a confidential test where the result becomes part of your medical record and can be given to your health care provider for HIV and other health care services, or
- You can choose to have an anonymous test, which means that you don't give your name and no record is kept of the test result. If your anonymous test is HIV-positive, you can choose to give your name later so you can get medical care more quickly.
- To get more information about options for testing and free or anonymous testing sites, ask your counselor/doctor or call 1-800-541-AIDS.

### **HIV testing is important for your health.**

- If your test result is negative, you can learn how to protect yourself from being infected in the future.
- If your test result is positive:
  - You can take steps to prevent passing the virus to others.
  - You can receive treatment for HIV and learn about other ways to stay healthy. As part of treatment, additional tests will be done to determine the best treatment for you. These tests may include viral load and viral resistance tests.

(10H-2556) (6/05) page 2 of 4

### **HIV testing is especially important for pregnant women.**

- An infected mother can pass HIV to her child during pregnancy or birth or through breastfeeding.
- It is much better to know your HIV status before or early in pregnancy so you can make important decisions about your own health and the health of your baby.
- If you are pregnant and have HIV, treatment is available for your own health and to prevent passing HIV to your baby. If you have HIV and do not get treatment, the chance of passing HIV to your baby is one in four. If you get treatment, your chance of passing HIV to your baby is much lower.
- If you are not tested during pregnancy, your provider will recommend testing when you are in labor. In all cases, your baby will be tested after birth. A positive test on your baby means that you have HIV and your baby has been exposed to the virus.

### **If you test positive:**

#### **State law protects the confidentiality of your test results and also protects you from discrimination based on your HIV status.**

- In almost all cases, you will be asked to give written approval before your HIV test result can be shared.
- Your HIV information can be released to health providers caring for you or your exposed child; to health officials when required by law; to insurers to permit payment; to persons involved in foster care or adoption; to official correctional, probation and parole staff; to emergency or health care staff who are accidentally exposed to your blood; or by special court order.
- The names of persons with HIV are reported to the State Health Department for tracking the epidemic and for planning services.
- The HIV Confidentiality Hotline at 1-800-362-5065 can answer your questions and help with confidentiality problems.
- The New York State Division of Human Rights at 1-800-523-2437 can help if you think you've been discriminated against based on your HIV status.

#### **Your counselor/doctor will talk with you about notifying your sex or needle-sharing partners of possible exposure to HIV.**

- Your partners need to know that they may have been exposed to HIV so they can be tested and get treated if they have HIV.
- If your health care provider knows the name of your spouse or other partner, he or she must report the name to the health department.
- Health department counselors can help notify your partner(s) without ever telling them your name.
- To ensure your safety, your counselor or doctor will ask you questions about the risk of domestic violence for each partner to be notified.
- If there is any risk, the Health department will not notify partners right away and will assist you in getting help.

(10H-2556) (6/05) page 3 of 4

## Informed Consent to Perform HIV Testing

My health care provider has answered any questions I have regarding HIV testing and has given me written information with the following details about HIV testing:



- HIV is the virus that causes AIDS.
- The only way to know if you have HIV is to be tested.
- HIV testing is important for your health, especially for pregnant women.
- HIV testing is voluntary. Consent can be withdrawn at any time.
- Several testing options are available, including anonymous and confidential.
- State law protects the confidentiality of test results and also protects test subjects from discrimination based on HIV status.
- My health care provider will talk with me about notifying my sex or needle-sharing partners of possible exposure, if I test positive.

I agree to testing for the diagnosis of HIV infection. If I am found to have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

### For pregnant women only:

In addition to the testing described above, I authorize my health care provider to repeat HIV diagnostic testing later in this pregnancy. I understand that my health care provider will discuss this testing with me before the test is repeated and will provide me with the test results. The consent to repeat diagnostic testing is limited to the course of my current pregnancy and can be withdrawn at any time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Test subject or legally authorized representative)

If legal representative, indicate relationship to subject: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

Except for expedited HIV testing on labor units, this form replaces other HIV testing consent forms as of June 1, 2005.

NOTE: this form is intended to be used in conjunction with DOH-2556i, Part A.

DOH-2556 (5/05)



## HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV\* Related Information

New York State Department of Health

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

- I consent to disclosure of (please check all that apply):
- My HIV-related information
  - Both (non-HIV medical and HIV-related information)
  - My non-HIV medical information \*\*

### Information in the box below must be completed.

<p>Name and address of facility/person disclosing HIV-related and/or medical information:</p> <p>_____</p> <p>_____</p> <p>Name of person whose information will be released: _____</p> <p>Name and address of person signing this form (if other than above):</p> <p>_____</p> <p>_____</p> <p>Relationship to person whose information will be released: _____</p> <p>_____</p> <p>Describe information to be released: _____</p> <p>Reason for release of information: _____</p> <p>Time Period During Which Release of Information is Authorized From: _____ To: _____</p> <p>Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any:</p> <p>_____</p> <p>_____</p> <p>Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):</p> <p>_____</p> <p>_____</p>
<p>All facilities/persons listed on pages 1,2 (and 3 if used) of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize.</p> <p>Signature _____ Date _____</p>

\*Human Immunodeficiency Virus that causes AIDS

\*\* If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

**HIPAA Compliant Authorization for Release of Medical Information  
and Confidential HIV\* Related Information**

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**Complete information for each facility/person to be given general medical information and/or HIV-related information.  
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

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Name and address of facility/person to be given general medical and/or HIV-related information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for release, if other than stated on page 1:

\_\_\_\_\_  
\_\_\_\_\_

If information to be disclosed to this facility/person is limited, please specify:

\_\_\_\_\_  
\_\_\_\_\_

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Name and address of facility/person to be given general medical and/or HIV-related information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for release, if other than stated on page 1:

\_\_\_\_\_  
\_\_\_\_\_

If information to be disclosed to this facility/person is limited, please specify:

\_\_\_\_\_  
\_\_\_\_\_

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The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or (212) 480-2522 or the New York City Commission on Human Rights at **(212) 306-7500**. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: \_\_\_\_\_

Print Name \_\_\_\_\_

Client/Patient Number \_\_\_\_\_

**HIPAA Compliant Authorization for Release of Medical Information  
and Confidential HIV\* Related Information**

**Complete information for each facility/person to be given general medical information and/or HIV-related information.  
Attach additional sheets as necessary. Blank lines may be crossed out prior to signing.**

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Name and address of facility/person to be given general medical and/or HIV-related information:

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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Name and address of facility/person to be given general medical and/or HIV-related information:

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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Name and address of facility/person to be given general medical and/or HIV-related information:

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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If any/all of this page is completed, please sign below:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Client/Patient Number \_\_\_\_\_



## SAMPLE HEALTH CARE PROVIDER VISIT RECORD

*Source: Kinship Family and Youth Services*

Name of Child:	Date of Birth: M ___ D ___ Y ___
Name of Foster Family:	Date of Visit: M ___ D ___ Y ___
Name of Provider:	
Provider Address:	
Reason for Visit:	
Outcome/Results (or Dx and Plan):	
Follow up/ Next Appointment	<input type="checkbox"/> None Needed <input type="checkbox"/> Date: M ___ D ___ Y ___    Time: ___ : ___ <input type="checkbox"/> am <input type="checkbox"/> pm
<b>Signatures</b>	
Health Care Provider	Name:
	Signature:
<b>Attending with Child</b>	
Birth Parent	Name:
	Signature:
Foster Parent	Name:
	Signature:
Staff	Name:
	Signature:



## SAMPLE MENTAL HEALTH CARE PROVIDER VISIT RECORD

*Source: Kinship Youth and Family Services*

Name of Child:		Date of Birth: M____D____Y____	
Name of Foster Family:		Date of Visit: M____D____Y____	
Mental Health Care Provider:			
Provider Address:			
Type of Visit:	<input type="checkbox"/> Individual Therapy <input type="checkbox"/> Group Therapy <input type="checkbox"/> Initial Psychiatric Evaluation <input type="checkbox"/> Initial Psychological Evaluation	<input type="checkbox"/> Psychometric Assessment <input type="checkbox"/> Family Therapy <input type="checkbox"/> Psychological Consultation	
Reason for Visit:	<input type="checkbox"/> Initial <input type="checkbox"/> Follow up <input type="checkbox"/> Emergency (crisis)	<input type="checkbox"/> Medication <input type="checkbox"/> Drugs and Alcohol	
Medications/Dosage:			
Medication Change:			
Reason for Change:			
Desired Result/ Expected Timeframe:			
Follow up/ Next Appointment:	Date: M____D____Y____ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm		
<b>Signatures</b>			
Health Care Provider	Name:		
	Signature:		
<b>Attending with Child</b>			
Birth Parent	Name:		
	Signature:		
Foster Parent	Name:		
	Signature:		
Staff	Name:		
	Signature:		



## SAMPLE SERVICE AGREEMENT

Provider and Agency  
(Period: 00/00/00 – 00/00/00)

### **PARTIES TO THE AGREEMENT**

Health Care Provider/Hospital located at: \_\_\_\_\_

Agency located at: \_\_\_\_\_

### **PURPOSES OF THE AGREEMENT**

The expressed purpose of this Agreement is to facilitate access to comprehensive, coordinated health care services for children in the care of Agency.

### **RESPONSIBILITIES OF THE PARTIES**

A. Provider agrees to:

1. Provide general medical services at Provider's location.
2. Include, at a minimum, the standards outlined in the schedule of examinations. In addition, the requirements of the local district and/or court orders will be met. Admission, discharge, transfer, and AWOL physicals will be completed according to the agency guidelines.
3. Provide the following services when such services are needed and requested:
  - 24-hour Emergency Medical Services at the Provider's Emergency Department.
  - Clinic services at the Provider's clinics.
  - In-patient hospitalization as required.
4. Make available staff members who are duly licensed, qualified, and privileged to render services as required by JCAHO standards.
5. Provide written information summarizing diagnosis, procedures, and treatment and further recommendations for each child. Where the child has been hospitalized on an inpatient basis, Provider agrees to provide ongoing information regarding the child's condition, recommendations, and discharge plans, as well as provide a written discharge summary following discharge from the hospital.
6. Coordinate medical services for child in such a manner as to minimize the number of visits to the clinic.
7. Inform and train Provider's staff regarding confidentiality and disclosure requirements of New York State statutes and regulations, including those provisions concerning HIV-related information, and agree to comply with such requirements.
8. Obtain payment for services by the agency directly or through the child's health insurance, Medicaid, parent, or legal guardian, as directed by the agency.

*Service Agreement, continued . . .*  
*Sample Service Agreement, continued*

9. Provide a consistent primary care provider with whom the child can have an ongoing relationship.
10. Primary care providers and other providers, as appropriate, to participate in joint case conferences as requested by Agency.
11. Primary care provider and other providers, as appropriate, to discuss the child's needs with the foster parents and the biological parents (if available), so they have a clear understanding of their responsibilities in the child's care according to all applicable laws.

B. Agency agrees to:

1. Maintain a roster of personnel authorized to make referrals for emergency services and clinic appointments.
2. Provide the necessary and pertinent clinical information on the child being referred.
3. Provide appropriately signed consent forms for treatment. The parent or legal guardian of the child must sign consents for non-emergency, in-patient hospitalizations. Agency will assist Provider to obtain parental or guardian consent whenever such consent is required.
4. Provide or arrange for transportation to Provider.
5. Provide, when appropriate, a child care staff member or family member to accompany the child or remain with the child who has been hospitalized. Child care coverage and duration will be determined on a case-by-case basis.
6. Assist in identifying third party payers and provide all available insurance information to Provider.

***This Agreement may be terminated by either party upon thirty (30) days written notice.***

---

Executive Director Signature  
Agency Name

Date

---

President/CEO Signature  
Provider Name

Date

### Application for Discrete Medicaid Rate

Please fill in below and return with a completed DOH-4224 NYS Department of Health *Medical Services Expenditure Distribution Sheet – General Care* (previous DSS 2660) or DOH 4225 NYS Department of Health *Medical Services Expenditure Distribution Sheet – Special Care* (previous DSS 2660-01) of your agency’s most recent reporting period’s medical services costs to the Office of Children and Family Services Regional Office. If you have an existing general care rate and are applying for a special population rate, submit your agency’s DOH-4224 of the last completed rate year if revisions were made to that form.

**I. Agency Information**

Agency Name: \_\_\_\_\_

Agency Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Agency MMIS ID #: \_\_\_\_\_

Proposed Program Size (Number of beds/slots) \_\_\_\_\_

**II. Special Program Requested (Check one)**

General

Special  
AIDS  
Boarder Babies  
Maternity  
Hard to Place  
Therapeutic Boarding Home  
Diagnostic  
Special Other

Note: If you are applying for more than one separate rate, complete one application form for each program for which you are applying.

If you have questions about completing the DOH-4224 or DOH-4225 for budgeting purposes, please contact Robert Payne of the Department of Health (DOH) at 518-473-8910. Also, for approved Medicaid per diems, you are required to report actual expenditures and revenues as follows:

- A.) DOH’s financial reporting requirements – The details of your actual expenditures and revenues for all MA per diem programs must be reported annually to DOH as an electronic submission of the DOH-4224 and DOH-4225. If you need a User-ID, contact your agency’s Health Provider Network (HPN) Coordinator, or call Robert

**Bureau of Waiver Management**  
**Application for Discrete Medicaid Rate**

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Payne at (518) 473-8910. Also, if you need instructions regarding the use of the HPN system for submitting the DOH-4224 and DOH-4225, you should again contact Robert Payne at (518) 473-8910.

- B.) OCFS' financial reporting requirements - Your actual expenditures and revenues for all Medicaid per diem programs must be reported annually (in one combined cost center) to OCFS as part of your agency-wide Statewide Standards of Payment (SSOP) submission. The Standards of Payment manual and other information related to your SSOP submission is available at <http://www.ocfs.state.ny.us/main/rates/>. Questions may be emailed to [ocfs.sm.ssop@ocfs.state.ny.us](mailto:ocfs.sm.ssop@ocfs.state.ny.us).

DOH Provider Manuals with policy and billing guidelines are available at: <http://www.emedny.org/ProviderManuals/ChildCare/index.html>

**III. Narrative Justification**

- A.) Provide a brief over of the agency including the types of programs provided and number of children served within each program area.
- B.) The ages and health background of the children for whom the program is targeted. This must include the clinical characteristics of the children as well as the level of severity and diagnostic categories.
- C.) Provide a description of the children's previous involvement in the child welfare system. For instance, do you anticipate that the children to be served in this program will have prior foster care placements. If so, what level of health care may have been provided and how do you anticipate continuing the treatment plan? If not, how do you intend on arranging for medical, dental, mental health, substance abuse and mental health assessments and on-going care.
- D.) The model of treatment, including the health care services, both routine and exceptional, which will be provided.
- E.) Provide a description of how the agency intends on coordinating the health care of the children within the program. This should also include a description of how the treatment plan will be integrated within the overall goals of each child while both in care and upon discharge from care.
- F.) Provide a description of how the agency addresses trauma for children within the program.
- G.) Provide a description of how the agency intends on developing and implementing individualized safety plans.
- H.) Provide a description of how the agency intends on offering behavioral support to children in the program.
- I.) Include a description of how each proposed staff person (both direct health care staff and administrative staff) support the service needs of the target population. This should also include how each staff will work together.
- J.) How you propose to meet the medical requirements of the Child Teen Health Program (CTHP) and the regulations and administrative directives of the Department of Health and the Office of Children and Family Services.
- K.) Include a description on how the agency intends on providing alcohol and substance abuse services.

**III. Budget Justification**

Please explain, next to each cost center, what is included in the dollar amount that you have for that cost center. Specify number of Full-time equivalents (FTE's) or service units (e.g. visits, encounters). Indicate, with as much specificity as possible, how and by whom these services have been/will be provided (e.g. salaried staff, contract, clinic, etc.). If possible, include letters of agreement/referrals with medical providers.

EXAMPLE: the program anticipates serving 50 children over the course of a year. Provide the number of physician visits, including initial assessments, routine well-child visits, discharge visits as well as any potential sick-child visits. If the agency intends on using a contract physician, indicate the number of visits and the fee for each visit (250 visits x \$100 per visit = \$25,000). If on the other hand, the physician is a salaried staff, then indicate the percent of the employees time devoted to serving the anticipated number of children by the annual salary (20% x \$150,000 = \$30,000).

- 01 - Physicians
- 02 - Psychiatrist
- 03a - Psychological Services
- 03b - Certified Social Workers
- 04 - Dental
- 05 - Specialists
- 06 - Nursing Services
- 07 - Medical Administration
- 08 - Medical Supplies & Equipment
- 09 - Medical Transportation
- 10 - Central Administration
- 11- Administrative Overhead
- 12 - Property
- 13 - Hospital/Clinical
- 16 - Number of Care Days

Answer the following questions:

1. How you calculated the proposed per diem.
2. What is the total number of bed/slots available for this program?
3. What percentage of occupancy did you apply against that figure?
4. When did/will the program start?

Note: Please be aware that the same care days amount that you utilized in calculating the 'Foster Care and Maintenance' portion of your budget must also be used in calculating your Medicaid per diem for this program.

**IV. Special Population Approvals**

If you are applying for AIDS, Boarder Babies, Maternity, Hard to Place, Therapeutic Boarding Home, Diagnostic rate, then answer the following questions.

1. How many children will this program serve?
2. How many care days?
3. What level of occupancy is expected?
4. What counties will this program draw from?
5. Who are the local contacts in each county to be served?
6. What is the total cost of the program?
7. What is the administrative cost of this program?
8. What is the administrative ratio of this program?
9. What is the untrended per diem?
10. How does this relate to other existing programs?
11. Has this agency exceeded its parameters in the general care program?
12. Could this program be operated within the expenditure levels of general care?
13. How many other foster care programs does this agency operate?
14. Why does this agency need this program?
15. Is it required by a directive of a LDSS?

**Voluntary Agency Health Services  
New Medicaid Rates Approval Process**

- I. Voluntary Agency submits completed Application Package to Office of Children and Family Services (OCFS) Regional Office. Regional Office staff will review the health services program.

Application Package includes:

- Application for Discrete Medicaid Rate
- DOH-4224 – NYS Department of Health *Medical Services Expenditure Distribution Sheet – General Care*  
Or
- DOH-4225 - NYS Department of Health *Medical Services Expenditure Distribution Sheet – Special Care*

- A. OCFS Regional Office forwards a copy of the completed application to the OCFS Bureau of Waiver Management (BWM) at:

Attention: Mimi Weber  
Office of Children and Family Services  
Bureau of Waiver Management  
52 Washington Street, 337 North  
Rensselaer, NY 12144

- II. The OCFS BWM will review the proposal and work with the voluntary agency to refine the proposal and to assess whether the application meets the standards and requirements of OCFS and DOH.

- III. OCFS will convene a panel of health professionals from relevant state agencies including the Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), Office of Mental Retardation and Developmental Disabilities (OMRDD), DOH, and OCFS to discuss the proposed health services. The panel may request additional information/clarification or may find the health proposal acceptable.

- A. If more information is requested, BWM will contact the applicant directly, in consultation with the Regional Office Staff.
- B. If no more information is requested, BWM will prepare the OCFS Transmittal Letter for the DOH Office of Health Insurance Programs (OHIP) with a copy to the DOH Bureau of Long-Term Care and Reimbursement (BLTCR).

Package will include:

- Transmittal Letter
- Application
- DOH 4224 or DOH 4225

**Bureau of Waiver Management (BWM)  
PROCESSES & PROCEDURES**

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- IV. DOH will review the fiscal information and will notify OCFS BWM of their findings.
  - A. If acceptable, DOH will forward necessary information to the Division of Budget (DOB).
  - B. If DOH finds the application unacceptable, they will contact OCFS BWM for further information. OCFS and DOH may contact the voluntary agency for further details.
  
- V. DOB reviews the request. If DOB has any concerns, DOB will contact BWM Representative from BLTCR and/or Mimi Weber for BWM. Upon DOB approval, DOH will notify the applicant, as well as OHIP and OCFS through the MMIS Transmittal Letter.

Timeframes: To facilitate prompt processing of rate requests, OCFS will make an initial assessment of the application within 4-6 weeks of receiving the proposal, and will continue to work with agencies as the proposals are refined.



## Websites

### **Advocates for Youth**

[www.advocatesforyouth.org](http://www.advocatesforyouth.org)

Advocates for Youth, GLBTQ Youth

[www.advocatesforyouth.org/glbtc](http://www.advocatesforyouth.org/glbtc)

### **AIDS Treatment Data Network**

[www.atdn.org](http://www.atdn.org)

### **Al-anon-Alateen**

<http://www.al-anon.alateen.org/>

### **American Academy of Child and Adolescent Psychiatry (AACAP)**

AACAP Policy Statements

[http://www.aacap.org/cs/root/policy\\_statements/policy\\_statements](http://www.aacap.org/cs/root/policy_statements/policy_statements)

### **American Academy of Pediatrics (AAP)**

<http://www.aap.org>

Foster Care

<http://www.aap.org/healthtopics/fostercare.cfm>

Medical Home

<http://www.medicalhomeinfo.org/>

AAP periodicity schedule

<http://practice.aap.org/content.aspx?aid=1599>

Policies, Reports, Guidelines

<http://aappolicy.aappublications.org/>

### **American Professional Society on the Abuse of Children (APSAC)**

[www.apsac.org](http://www.apsac.org)

### **Association for the Treatment of Sexual Abusers (ATSA)**

[www.atsa.com](http://www.atsa.com)

### **Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents**

[www.brightfutures.org](http://www.brightfutures.org)

### **Child Abuse Evaluation and Treatment for Medical Providers**

<http://www.childabusemd.com/>

### **Child Advocacy Resource and Consultation Center (CARCC)**

[www.nyscarcc.org](http://www.nyscarcc.org)

**Child Welfare Information Gateway**

<http://www.childwelfare.gov/>

**Controlled Substances**

<http://www.deadiversion.usdoj.gov/schedules/index>

**Controlled Substances: Definition of Schedules**

<http://bfa.sdsu.edu/ehs/deasched.htm>

**Denver Developmental Materials, Inc.**

<http://www.denverii.com/>

**Healthy People 2010**

<http://www.healthypeople.gov>

**I Wanna Know (American Social Health Association)**

<http://www.iwannaknow.org/>

**It's Your (Sex) Life (Kaiser Family Foundation)**

[www.itsyoursexlife.org](http://www.itsyoursexlife.org)

**KidsHealth (Nemours Foundation)**

<http://kidshealth.org/>

Growth and Development Charts

[www.kidshealth.org/parent/growth/growth/growth\\_charts.html](http://www.kidshealth.org/parent/growth/growth/growth_charts.html)

**MedlinePlus**

<http://medlineplus.gov/>

**Mental Health Association in New York State, Inc.**

<http://www.mhanys.org/>

**National Alliance for Drug Endangered Children**

<http://www.nationaldec.org/>

**National Alliance on Mental Illness**

<http://www.nami.org/>

**National Child Traumatic Stress Network**

[http://www.nctsn.org/nccts/nav.do?pid=hom\\_main](http://www.nctsn.org/nccts/nav.do?pid=hom_main)

**National Institute for Health Care Management (NIHCM)**

<http://www.nihcm.org/>

**National Youth Anti-Drug Media Campaign**

<http://www.theantidrug.com/>

**New York City Immunization Registry**

<http://www.nyc.gov/html/doh/html/cir/index.html>

**New York Codes, Rules and Regulations (NYCRR)**

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

**New York State Citizen's Coalition for Children, Inc.**

<http://www.nysccc.org/>

**New York State Laws**

<http://public.leginfo.state.ny.us/menugetf.cgi>

**New York State Department of Health**

<http://www.health.state.ny.us/>

Childcare Agency Provider Manual

<http://www.emedny.org/ProviderManuals/ChildCare/index.html>

Child Teen Health Plan

<http://www.emedny.org/ProviderManuals/EPSTDCTHP/index.html>

Early Intervention Program

[http://www.health.state.ny.us/community/infants\\_children/early\\_intervention/](http://www.health.state.ny.us/community/infants_children/early_intervention/)

Electronic Medicaid System of New York State

<http://www.emedny.org/>

HIV/AIDS

[www.health.state.ny.us/nysdoh/aids/index](http://www.health.state.ny.us/nysdoh/aids/index)

HIV Clinical Resource, AIDS Institute

[www.hivguidelines.org](http://www.hivguidelines.org)

Immunization Information System (NYSIIS)

[http://www.health.state.ny.us/prevention/immunization/information\\_system/](http://www.health.state.ny.us/prevention/immunization/information_system/)

Immunization Schedule

[http://www.health.state.ny.us/prevention/immunization/childhood\\_and\\_adolescent](http://www.health.state.ny.us/prevention/immunization/childhood_and_adolescent)

Medicaid "Carveout" Prescriptions

[http://www.health.state.ny.us/health\\_care/medicaid/program/carveout.htm](http://www.health.state.ny.us/health_care/medicaid/program/carveout.htm)

Newborn Screening Program

Wadsworth Center, New York State Department of Health

[www.wadsworth.org/newborn](http://www.wadsworth.org/newborn)

Resource Directory for Children with Special Health Care Needs

<http://www.health.state.ny.us/publications/0548.pdf>

**New York State Office of Alcoholism and Substance Abuse Services (OASAS)**

<http://www.oasas.state.ny.us/index.cfm>

Fetal Alcohol Spectrum Disorders (FASD)

<http://www.oasas.state.ny.us/fasd/index.cfm>

Methamphetamine Clearinghouse

<http://www.oasas.state.ny.us/meth/index.cfm>

Prevention Programs (search)

<http://www.oasas.state.ny.us/preventionDirectory/index.cfm>

Treatment Providers (search)

<http://oasasapps.oasas.state.ny.us/portal/pls/portal/oasasrep.dynprovsearch.show>

**New York State Office of Children and Family Services**

<http://www.ocfs.state.ny.us/main/>

Bridges to Health (B2H)

<http://www.ocfs.state.ny.us/main/b2h/>

Health Services for Children in Foster Care

[http://www.ocfs.state.ny.us/main/sppd/health\\_services/new.asp](http://www.ocfs.state.ny.us/main/sppd/health_services/new.asp)

Policies (Administrative Directives, Informational Letters, Local Commissioner Memorandum)

<http://www.ocfs.state.ny.us/main/policies/external/>

Reports

<http://www.ocfs.state.ny.us/main/reports/>

**New York State Office of Mental Health**

<http://www.omh.state.ny.us/>

Clinic-Plus Program

[http://www.omh.state.ny.us/omhweb/clinicplus/support\\_network/providers/guidance.html](http://www.omh.state.ny.us/omhweb/clinicplus/support_network/providers/guidance.html)

Suicide Prevention, Education, and Awareness Campaign (SPEAK)

<http://www.omh.state.ny.us/omhweb/speak/index.htm>

Treatment of Children with Mental Health Disorders

<http://www.omh.state.ny.us/omhweb/booklets/ChildrensBook.htm>

**New York State Office of Mental Retardation and Developmental Disabilities**

<http://www.omr.state.ny.us/>

**Obesity Resource (Connect for Kids)**

[http://www.connectforkids.org/obesity\\_resource](http://www.connectforkids.org/obesity_resource)

**Permanent Judicial Commission on Justice for Children**

<http://www.courts.state.ny.us/ip/justiceforchildren/>

**Safer Society Foundation, Inc.**

[www.saferociety.org](http://www.saferociety.org)

**Sex, Etc. (Network for Family Life Education, State University of New Jersey at Rutgers)**

<http://www.sexetc.org>

**Sickle Cell Information Center**

[www.scinfo.org/index.htm](http://www.scinfo.org/index.htm)

**Statewide School Health Services Center**

<http://www.schoolhealthservices.org/>

**STD Treatment Guidelines**

<http://www.cdc.gov/STD/treatment/default.htm>

**Teenwire (Planned Parenthood Federation of America)**

[www.teenwire.org](http://www.teenwire.org)

**U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA)**

<http://www.samhsa.gov/>

Caring for Every Child's Mental Health

<http://mentalhealth.samhsa.gov/child/default.asp>

Family Guide to Keeping Youth Mentally Health and Drug Free

<http://www.family.samhsa.gov/>

FASD

<http://www.fascenter.samhsa.gov/index.cfm>

National Clearinghouse for Drug and Alcohol Information

<http://ncadi.samhsa.gov/>

(search for Screening and Assessing Adolescents for Substance Use Disorders Treatment Improvement Protocol (TIP) Series 31 and Treatment and Adolescents with Substance Use Disorders TIP Series 32 from this screen)

# Working Together

## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

NYS Office of Children and Family Services

### Appendix B

## Selected Health-Related Policies

### Administrative Directives

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### General Information System Messages (Department of Health)

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# *Working Together*

HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

*NYS Office of Children and Family Services*



**Eliot Spitzer**  
Governor

**NEW YORK STATE**  
**OFFICE OF CHILDREN & FAMILY SERVICES**  
52 WASHINGTON STREET  
RENSSELAER, NY 12144

**Gladys Carrión, Esq.**  
Commissioner

### **Administrative Directive**

<b>Transmittal:</b>	08-OCFS-ADM-01
<b>To:</b>	Commissioners of Social Services Executive Directors of Voluntary Authorized Agencies
<b>Issuing Division/Office:</b>	Strategic Planning and Policy Development
<b>Date:</b>	February 13, 2008
<b>Subject:</b>	Changes associated with CONNECTIONS Build 18.9: Health, Education and Permanency Hearing Report Modules
<b>Suggested Distribution:</b>	Directors of Services Child Protective Services Supervisors Child Welfare Supervisors Legal Staff Staff Development Coordinators CONNECTIONS Implementation Coordinators Voluntary Agency Program Directors
<b>Contact Person(s):</b>	Questions concerning this release should be directed to your Regional Office, Division of Child Welfare and Community Services: Buffalo Regional Office – Mary Miller (716) 847 – 3145 <a href="mailto:Mary.Miller@ocfs.state.ny.us">Mary.Miller@ocfs.state.ny.us</a> Rochester Regional Office – Linda Kurtz (716) 238 – 8200 <a href="mailto:Linda.Kurtz@ocfs.state.ny.us">Linda.Kurtz@ocfs.state.ny.us</a> Syracuse Regional Office – Jack Klump (585) 423 – 1200 <a href="mailto:Jack.Klump@ocfs.state.ny.us">Jack.Klump@ocfs.state.ny.us</a> Albany Regional Office – Glenn Humphreys (518) 486-7078 <a href="mailto:Glenn.Humphreys@ocfs.state.ny.us">Glenn.Humphreys@ocfs.state.ny.us</a> Yonkers Regional Office – Patricia Sheehy (914) 377 – 2080 <a href="mailto:Patricia.Sheehy@dfa.state.ny.us">Patricia.Sheehy@dfa.state.ny.us</a> New York City Regional Office – Patricia Beresford (212) 383-1788 <a href="mailto:Patricia.Beresford@ocfs.state.ny.us">Patricia.Beresford@ocfs.state.ny.us</a> Native American Services – Kim Thomas (716) 847 – 3123 <a href="mailto:Kim.Thomas@ocfs.state.ny.us">Kim.Thomas@ocfs.state.ny.us</a>
<b>Attachments:</b>	Yes
<b>Attachment Available Online:</b>	Yes Attachment A: “ Build 18.9 Business Functions”

Attachment B: List and Link to JOB Aids  
<http://ocfs.state.nyenet/connect/security/Build%2018%209%20BF%20%2001-25-07.pdf>

### Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
05 OCFS ADM-02 04-OCFS-LCM-04 97 ADM-15		18 NYCRR Parts 357, 428, 432, 441, 466 and 508; 18 NYCRR 360.8.1 and 463.2	SSL §§ 373- a,409, 422, and 446  FCA Articles 3, 7, 10 FCA §1089  Public Health Law Articles 17 and 27-F  MHL §22.11 MHL §33.21	NYS OCFS Manual, “Working Together: Health Services for Children in Foster Care.”	SSA § 475(l)(C) 42 U.S.C. 675  EPSDT 5123.2  Public Law 107- 133

#### I. Purpose

In March 2007, the Office of Children and Family Services (OCFS) implemented Build 18.9 in CONNECTIONS. Included in Build 18.9 were discrete modules that supported the documentation of currently required health and education information for children served through the child welfare system; the incorporation of the Permanency Hearing Report (PHR), the Notice of Permanency Hearing and the Statement to the Court of the Permanency Hearing Report and Notice Sent; as well as additional functional improvements that provide ease of use for workers and aid in system responsiveness.

At the time of the implementation of Build 18.9 in CONNECTIONS, OCFS provided local Departments of Social Services (LDSS) with the option to implement an incremental approach to full compliance with the documentation requirements of health and education in CONNECTIONS. This ADM will serve as official notification of what health and education data must now be included in CONNECTIONS for all children in foster care, including children placed in certified or approved foster homes, and all children in the custody of LDSS or OCFS placed in congregate care settings in Voluntary Authorized Foster Care Agencies (VA).

In addition, this ADM will identify significant changes and enhancements in CONNECTIONS Build 18.9 designed to capture essential data elements required to support New York State compliance with the federal Adoption and Foster Care Analysis Reporting System (AFCARS).

## **II. Background**

The documentation of health and education information for children and families served through the child welfare system has been an essential requirement identified in both federal and state laws and regulations for some time. The documentation of this information in CONNECTIONS in discrete data fields is a new method of documenting critical case information. The new modules provide an organized, central location for staff to enter and view essential health and education information for all children they are responsible for serving through the child welfare system. The new modules also support the collection of essential health care and education data for children in foster care that is required by the federal government in the AFCARS data report that is submitted twice each year.

Section 446 of the Social Services Law (SSL) authorizes the creation of the state's single statewide automated child welfare system.

OCFS regulation 18 NYCRR 466.3 states that upon issuance of an administrative directive by OCFS indicating that information regarding a child welfare service or services must be entered into the CONNECTIONS system, each social services district or public or private agency providing such service that has access to the CONNECTIONS system must use the CONNECTIONS system or record the information in the form and manner prescribed by OCFS to satisfy the data requirements for the particular service.

Section 373-a of the SSL requires that to the extent medical histories 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 biological parents, with information identifying such parents eliminated, must 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. In addition, to the extent available, the medical histories 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 and upon request to any adopted former foster child; provided, however, medical histories of biological parents shall be provided to an adoptee with information identifying such biological 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 natural 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. See also OCFS regulations 18 NYCRR 357.3 and 428.8.

OCFS regulations also require every authorized agency to maintain current case records for each child in its care, which must include medical histories of a child and his or her biological family, and a continuing medical record and dental history for each child [18 NYCRR 428.3(b)(2)(ii) and 441.7(a)(1)].

OCFS regulations also require every authorized agency to maintain educational information about foster children and, to the extent available, 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. 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 [18 NYCRR 357.3 (j)].

Federal law, [section 475(l)(C) of the Social Security Act (SSA)], requires the collection of case plans that include the most recent information available regarding the health records and educational status and services provided to foster children. Federal law also requires the state to collect and report certain data elements to AFCARS for children in foster care and who have been adopted.

The federal and state statutory and regulatory standards pertaining to medical consents, confidentiality of health-related information (including confidential HIV-related information), and acquisition and dissemination of medical history information and educational information will remain the same with the implementation of CONNECTIONS Build 18.9. A description of the effects of the Health Insurance Portability and Accountability Act (HIPAA) on access to health-related information and disclosure of health-related information can be found in 05-OCFS-ADM-02.

Chapter 3 of the Laws of 2005, also known as the Governor's Permanency Law, affects the Family Court, social services districts and voluntary authorized agencies and provides that a PHR be provided to the Family Court and certain other persons in regard to abused, neglected, voluntarily placed and completely freed foster children. The provisions of Chapter 3 of the Laws of 2005 that relate to the PHR were effective December 21, 2005.

The PHR provides the Family Court with the information needed to make decisions regarding the safety and well-being of the child, the family's progress, the plan for achieving timely permanency for the child, and the reasonable efforts to finalize that plan. The requirements for the PHR are detailed in section 1089 of the Family Court Act (FCA). OCFS, in

collaboration with the Office of Court Administration (OCA) and with input from a number of local districts, developed a series of templates for the required PHR to be used statewide by LDSS and VA child welfare caseworkers. These templates, as well as the associated Notice of Permanency Hearing and the Statement to the Court of the Permanency Hearing Report and Notice Sent, have been promulgated as OCA forms. Build 18.9 has incorporated these templates and associated forms directly into the CONNECTIONS application, and certain health and education information and information from the most recent Family Assessment and Service Plan (FASP), at worker choice, may be pre-filled into the PHR.

**Please note:** With regard to any records kept (including those outside of CONNECTIONS), the records of a non-adopted child in foster care must be retained for 30 years following the discharge of the child from foster care. Records of the child receiving preventive services alone must be retained for six years after the 18<sup>th</sup> birthday of the youngest child in the family. [See 18 NYCRR 428.10(a)(5)(ii)]. Records of child protective services must be retained in accordance with sections 422(5), 422(6) and 422(8) of the SSL and 18 NYCRR 432.9(f). Records of an adopted child must be sealed and permanently retained. [See 18 NYCRR 428.10(a)(5) and 05-OCFS-ADM-02.]

### **III. Program Implications**

#### **A. Health Services Module**

The CONNECTIONS Health Services Module has been designed to provide a systematic and organized presentation of the general health history and other critical health information pertinent to a child being served through the child welfare system.

This module fulfills several purposes.

- Primarily, it allows the child's case manager, case planner, associated caseworker, agency nurse, or health care coordinator easy access to the most critical health information for the child.
- The module also provides an overview of the status of required health activities, such as routine health evaluations and HIV risk assessments.
- Information from the health services module may be pre-filled into the PHR.
- Certain diagnoses recorded in the module are captured by the OCFS Data Warehouse for mandated federal AFCARS reports. Non-compliance with these reporting requirements may have a negative fiscal impact on child welfare operations in NYS.
- Data from the health services module can inform LDSS, VAs and OCFS of important trends and issues related to the health of children in foster care.

The Health Services Module is available for every child who is identified in CONNECTIONS as a “tracked” child. Information in Health Services is discretely entered for each individual child and can only be maintained and/or viewed by persons with an appropriate role in a case and those with access to their workload, or through special security business functions.

*The Health Services Module is not intended to be a comprehensive health record or a substitute for the medical records maintained by the social services district, authorized agency, or the child’s medical provider.* As is required now, there must still be external documentation maintained that includes:

- copies of lab tests,
- physician forms,
- immunization records,
- medical consent forms,
- psychiatric evaluations,
- copies of referrals to medical providers, and so on.

Because it is not necessary to enter all of the child’s medical appointments or services into CONNECTIONS, the external medical file will be the more complete record. The child’s medical providers will have the most comprehensive record of all and, as such, will likely be timelier than what the district or agency possesses.

Information that must be entered into the Health Module is listed in the **Requirements** section below.

#### **Legal Authority/ Regulations for the Provision of Health Services**

All children in foster care must be provided certain health services. The required activities for the provision of health services are outlined in 18 NYCRR 441.15, 441.22, and 442.21; as well as in the NYS OCFS Manual **Working Together: Health Services for Children in Foster Care**; and the Title XIX (Medicaid) Early Periodic Diagnostic, Screening and Treatment (EPSDT) guidance available on the NYS Department of Health website.

This section of the Administrative Directive provides social services districts and voluntary authorized agencies with information on the current requirements for the provision of health services. The above referenced regulations did not change with the implementation of Build 18.9.

According to 18 NYCRR 441.22, each authorized agency is responsible for providing comprehensive medical and health services for every foster child in its care. This care must be provided by qualified persons. Social services districts and voluntary authorized agencies that provide foster care are also responsible for providing appropriate psychiatric, psychological and other essential services appropriate to the needs of the children in care (18 NYCRR 441.15).

### **Basis for Elements in Health Services Module**

*Working Together* sets forth a five-assessment protocol that comprises the initial comprehensive health evaluation for each child entering foster care. Regulations or rationale for each assessment is as follows:

- Physical/Medical – 18 NYCRR 441.22(c)(2)
- Developmental – 18 NYCRR 441.22(c)(2); EPSDT 5123.2(A)(1)
- Dental – 18 NYCRR 441.22(c)(2)(vii)
- Mental Health – 18 NYCRR 441.15; EPSDT 5123.2(A)
- Substance Abuse – 18 NYCRR 508.8(b)(4)(iii)

In addition to the comprehensive evaluation, there are specific health services and information that are recorded in CONNECTIONS. The authority for these activities is as follows:

- HIV risk assessment for children in foster care – 18 NYCRR 441.22(b)
- Referral to the Early Intervention Program - 04-OCFS-LCM-04;
- Biological family health history – SSL§ 373-a, 18 NYCRR 357.3(b)

### **Documentation of Health Information**

According to OCFS regulation 18 NYCRR 428.1, social services districts must provide a thorough family assessment and an account of all family and children's services delivered to children and their families through case records maintained in the form and manner and at such times as required by OCFS for the following:

- all children placed in social services district custody, or considered for such placement, which includes all children placed by a court directly in the custody of a relative or other suitable person pursuant to Article 10 of the FCA;
- all children in receipt of mandated and non-mandated preventive services (as defined in section 409-a of the SSL);
- all children legally freed for adoption; and
- all children named in an indicated report of child abuse or maltreatment (as defined under 18 NYCRR 432.1).

In addition to the general requirement for case documentation above, OCFS regulation 18 NYCRR 428.3(b)(2)(ii) lists additional information and documents that must be included in the uniform case record for children in foster care. These include:

- 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;
- 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 capacity to consent, as applicable, regarding medical treatment for any child in foster care placement;
- documentation that the child has been assessed for risk factors related to HIV infection in accordance with 18 NYCRR 441.22(b), 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.

Historically, some of this information may have been documented in progress notes, the service plan, an external medical record, or the medical record component of the official case record. The form, manner and method of documenting specific health-related information and activities for children has changed in that now certain information must be entered into CONNECTIONS Health Services Module. However, the services and the need to document them have not changed.

### **Components of the Health Services Module**

The Health Services Module provides functionality to designate health responsibility for each child in foster care to the social services district or authorized agency with whom the child is placed. In addition to the “Designate Health Responsibility” window, there are six tabs in the module.

Child Health Info tab serves as an electronic face-sheet that provides a health “snapshot” for the child. This tab records allergies, durable medical equipment, medications, hospitalizations, after-hours contact, and primary care/medical home. The Child Health Info tab must be kept updated with current information.

Clinical Appointments tab captures the details of specific appointments. Included are the date, medical provider, domain, appointment type, diagnosis, and treatment recommendations. The tab also contains a check-box to indicate whether a child’s immunizations are up-to-date at the conclusion of the medical appointment. Certain diagnoses will be captured from this tab for federal AFCARS reports.

The five domains (physical/medical, developmental, dental, mental health, substance abuse) mirror the multi-assessment protocol put forth in the manual *Working Together: Health Services for Children in Foster Care*. Refer to this manual at [http://www.ocfs.state.ny.us/main/sppd/health\\_services/manual.asp](http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp) for additional information on the requirements and recommended best practices for each assessment, and the comprehensive health evaluation. More than one domain may be selected for an appointment, as the clinician may address multiple aspects of the child’s well-being. For example, pediatricians

routinely assess developmental as well as physical health in the course of an infant's well child appointment.

Early Intervention tab records the date that a child is referred to the Early Intervention Program (EIP), evaluation date, and information on the services and program provider. In accordance with 04-OCFS-LCM-04, LDSS must inform parents of children under the age of three who are subjects in an indicated report of child abuse or maltreatment of the Early Intervention Program, and refer them to their county's EIP. Unlike the other tabs in the health services module, access to the Early Intervention tab is available to any staff with a role in the case.

Bio Family Health Info tab records hereditary conditions of the child's biological family, information on the mother's pregnancy, and the biological parents' cause of death, if applicable. Information on the biological parents' HIV status *must not* be recorded on this tab or anywhere else in the CONNECTIONS system. The CONNECTIONS system does not have a built in system capability to limit access to confidential HIV-related information to only those persons authorized by statute to have access. Therefore, it is incumbent on the social services district or voluntary authorized agency to administer the system in a compliant manner.

HIV Risk Assessment tab is a dynamic window that asks a series of questions on the mandated HIV risk assessment process for children in foster care. Results of HIV tests and Newborn Screening are recorded. The HIV risk assessment tab is completed for children in foster care *only*.

Health Narrative tab is available to document sensitive health information that is not to be included in progress notes, such as HIV-related information, family planning, and information on reproductive rights or sexually transmitted diseases of the child.

Additionally, information in the Health Services Module may be efficiently pre-filled onto the PHR that is now supported in CONNECTIONS. There are several questions in the PHR directly related to the child's diagnoses, specific treatment(s), and medication(s) the child is taking, etc. This information is mapped directly from the Health Services Module into the PHR if the pre-fill option is selected in the PHR window. Using this efficiency, once the information is entered into the Health Services Module, there is no need for duplicate direct data entry by the worker into the PHR. The new PHR may be modified by the worker so that the health information is presented cohesively to the court.

Any changes to specific health information must be completed in CONNECTIONS to provide consistent access to the most current and accurate information related to the health needs of the child for all persons involved with the child who are legally permitted to view or maintain this information.

It is critical for staff to carefully review the newly generated PHR to protect the confidentiality of certain health information. Information may not be inappropriately shared with persons who, while having a legal right to receive a copy of the PHR, do not have a right to certain health information. For example, OCFS has taken specific steps to safeguard against the mapping or inclusion of confidential HIV-related information in the PHR.

### **Confidentiality**

The legal standards relating to the collection, maintenance, and disclosure of client identifiable child protective services, preventive services, foster care and adoption records remain unchanged by the implementation of CONNECTIONS Build 18.9. See 18 NYCRR 466.4 and 466.5 for further information on the confidentiality and security requirements for the CONNECTIONS system.

In general, health information received from a medical provider pursuant to an authorized request may be entered into the Health Services Module without obtaining additional consent from the protected individual. However, there are some circumstances that require special consideration.

### **HIV Information**

A child with capacity to consent to an HIV test may choose to take a confidential test arranged by the social services district or VA, an anonymous test, or refuse a test. If the child agrees to a confidential test, consent is to be obtained for the agency to receive the test results. A model form for this purpose can be found in 97 ADM-15, Appendix D. Test results from anonymous tests cannot be verified, as the patient's name is not associated to the test result.

- If the child consents to a confidential test, the test results are recorded in the HIV Risk Assessment tab.
- If the child agrees to an anonymous test, the results are not available from the provider that performed the test, and therefore cannot be entered into the system.
- If the child confides the results of an anonymous HIV test, encourage the child to agree to a confidential test so that the results can be confirmed and documented, and appropriate services arranged.

If a child is diagnosed with HIV infection, this diagnosis must be entered into the Clinical Appointments tab. The diagnosis will not automatically pre-fill into the PHR. ***Carefully review the PHR to determine if it contains information, such as medications for HIV infection, that recipients of the PHR do not have the right to know and edit accordingly.***

A positive HIV result on the Newborn Screening is not a diagnosis of HIV infection. Rather, it indicates that the child was exposed to HIV in utero. The health provider must adhere to current medical protocols for further testing

and follow-up of an HIV-exposed infant. Subsequent HIV tests for the infant are recorded as a routine HIV risk assessment (not Newborn Screening) in the HIV Risk Assessment tab. Health providers may refer to the following web link:

<http://www.hivguidelines.org/GuideLine.aspx?pageID=258&guideLineID=25>

Notes regarding HIV must be entered into the Health Narrative and *not* in Progress Notes. When it contains confidential HIV-related information, a Health Summary may only be shared with persons who have the right to access confidential HIV-related information. In such a situation, one option is to produce a Child Health History Report by manually selecting each tab to print, omitting the HIV Risk Assessment tab.

Confidential HIV-related information on anyone other than a foster child must not be entered into CONNECTIONS. The CONNECTIONS system does not have a built-in system capability to limit access to confidential HIV-related information to only those persons authorized by statute to have access. Therefore, it is incumbent on the social services district or voluntary authorized agency to administer the system in a compliant manner. If a parent has HIV/AIDS, reference may be made in the case record to the parent's serious chronic illness without naming the diagnosis.

### Reproductive Health

Minors also have the right to consent for reproductive health services and family planning services. However, a child in foster care may not need to assert that right, given the exercise of the right to consent from another source, such as a parent/ guardian or a local district. The child's ability to consent to services does not necessarily mean that the agency must request the child's permission to receive documentation of the service and enter it into the system.

The following scenarios provide further instruction on the confidentiality of reproductive health services. These apply to children in foster care.

1. Child receives routine reproductive health service (e.g., a pelvic exam) pursuant to an authorized consent signed by the parent for routine medical treatment. Information may be obtained from the provider and entered into the Health Services Module without further consent.
2. Child is prescribed contraceptives.
  - Because of possible side effects and interactions with other medications, this information, if obtained from the provider, must be included in the child's medical record irrespective of consent.
  - If this medication was prescribed pursuant to an authorized consent for routine medical treatment, the information may be obtained from the provider and entered into the Health Services Module without further consent.

- If the child independently sought and obtained the medication from a provider, the child's consent is required for the provider to disclose the information to the agency. If the child provides written consent, information may be obtained from the provider and entered into the system if the consent form allows redisclosure to any person who may access the information through the system. Carefully review the PHR and edit as necessary.
3. Child is treated for a sexually transmitted disease (STD) pursuant to an authorized consent for routine medical treatment (e.g., child was exposed to an STD as a result of sexual abuse). Information may be obtained from the provider and entered into the Health Services module without further consent.
  4. Child independently seeks treatment for an STD or termination of a pregnancy. Child consents to the treatment and confides the information to agency staff or a foster parent.
    - The information must not be shared with the child's parent/guardian without the child's express consent (see section 17 of the Public Health Law).
    - Child should be counseled on the need to share this information within the agency because of the implications for the child's overall health. If the child agrees and signs a written release, information may be obtained from the provider and entered into the system if the consent form allows redisclosure to any person who may access the information through the system.
    - If the child does not agree to share information, do not enter it into the system. The individual to whom the child has disclosed should balance the child's right to confidentiality against the agency's responsibility to protect the child's best interests in regard to safety, permanency and well-being. If it would be detrimental to the child's health if others in the agency were unaware of this information, a notation may be made in the medical record. Rather than entering the information in the clinical appointments tab, a note may be placed in the Health Narrative referring the reader to the agency medical record for further information.
    - Carefully review the PHR and edit as necessary.
  5. In accordance with 18 NYCRR 357.3, the child's medical history must be released to the parent when the child is discharged to the parent. In general, when a minor consents to her own reproductive health care, she may determine who is authorized to receive information about that care. Review the information and consents on file regarding the child's reproductive health services to determine if information may be released to the parent.

### Mental Health

Routine mental health services, including initial assessments and ongoing therapy, are provided to children in foster care pursuant to an authorized consent for routine medical treatment. Information may be obtained from the provider and entered into the Health Services Module without further consent. Diagnoses and psychiatric medications should be entered into the Clinical Appointments and Child Health Info tabs respectively. If direct quotes from a mental health evaluation report or licensed clinician's treatment notes are entered into the system, they must be put into the Health Narrative rather than Progress Notes.

A child may obtain mental health services absent parental consent in limited situations (see section 33.21 of Mental Hygiene Law [MHL]). The provider may require the consent of the child or a court order to release the records to the agency. Once obtained, this information may be entered into the system without further consent. Carefully review the PHR and edit as necessary.

### Substance Abuse Services

Substance abuse services, including initial assessments and ongoing treatment, are provided to children in foster care pursuant to an authorized consent for routine medical treatment. Information may be obtained from the provider and entered into the Health Services Module without further consent. Diagnoses of substance related disorders or dependencies should be entered into the Clinical Appointments tab. If direct quotes from a substance abuse evaluation report or licensed clinician's treatment notes are entered into the system, they must be put into the Health Narrative rather than Progress Notes.

A child may obtain treatment for chemical dependence absent parental consent in limited situations (see section 22.11 of the MHL). The provider may require the consent of the child or a court order to release the records to the agency. Once obtained, this information may be entered into the system without further consent. Carefully review the PHR and edit as necessary.

### Security for the Health Services Module

Due to the confidentiality and sensitive nature of the information contained in the Health Services tab, security for this function is necessarily more restrictive. This extra layer of security enhances protection for the confidentiality and privacy of the child and his or her family.

Access to the Health Services Module is granted based on:

- the worker's role in the stage,
- status of the stage,
- the designation of an agency with health responsibility for each child,
- user's access to a workload, and
- the assignment of two new business functions (BFs) – MAINT (Maintain) HEALTH and VIEW HEALTH.

The MAINT HEALTH BF permits a staff person in a district or designated agency who does not have a specific role in the case, such as a nurse, clinical director or health care coordinator, necessary access to health information based on their need to document critical health activities, track health progress and support follow-up treatment for the children, but limits access to other health information.

For specific details on security and access to the Health Services Module, refer to the **CONNECTIONS System Build 18.9 Job Aid: Health Services** and Online Help within the Health Services Module. Please note the enhanced security does not apply to the Early Intervention tab.

Provision of access to information within a social services district or voluntary agency with which a local district contracts is based upon the principle of persons who have a “need to know” specific information. Social services administrators, program directors and security administrators in social services districts and agencies must make specific decisions regarding who may have access to what records based upon their role in providing services to a child or family member and their unique need to know the information maintained in different parts of the case record. OCFS has disseminated specific guidelines for each BF to aid in this decision-making process. Staff should consult the OCFS Build 18.9 Business Function Guidelines prior to making assignment decisions (see Appendix A).

It is also important for the district/agency to establish a method to monitor and review the proper assignment of the new BFs “VIEW HEALTH” and “MAINT HEALTH” on a periodic basis to provide safeguards for the maintenance and confidentiality of this information.

### **Required Actions**

Entering and updating health-related information in the Health Services Module is *required* for:

- all children in foster care; and
- all children in OCFS custody placed in a Voluntary Agency (also included in the population referred to as “children in foster care”).

Detailed, step-by-step instructions for maintaining data fields in the Health Services Module are contained in the **CONNECTIONS System Build 18.9 Job Aid: Health Services**.

Required elements in the Health Services Module are as follows:

### **Designate Health Responsibility**

Designation of Health Responsibility is required to allow caseworkers with a role in the stage other than that of the Case Manager or Case Planner, and staff with the MAINT HEALTH or VIEW HEALTH business function access to

the Health Services Module. Designation must be completed for each child by the Case Manager or Case Planner upon the child's entry into foster care. Designation is necessary to enable access for a worker with the role of Caseworker, even if the Caseworker is in the same social services district as the Case Manager or Case Planner.

#### Child Health Info tab

To support the accuracy of critical health information, records from health providers must be in the agency's possession when entering information on an overnight hospitalization. Written documentation in the child's medical record or verification from the prescriber or the prescription itself must be obtained before entering medications into the system. This is particularly critical as many medications have similar spellings. Allergies and durable medical equipment reported by the parent/guardian must be entered into the system pending verification by a health provider. If dates for the onset of allergies, the use of durable medical equipment, and the first prescription of a medication for a chronic condition are unknown, they may be estimated using the protocols described in the Job Aid. This information must be updated whenever it changes.

Required fields on this tab are:

- Current allergies, medications, and durable medical equipment with start and end dates, as applicable;
- All overnight hospitalizations while the child is in foster care;
- To the extent known, overnight hospitalizations prior to foster care which are related to chronic health conditions or conditions that led to the child's removal;
- After Hours Agency Health Contact, as applicable;
- Primary Care/Medical Home provider.

#### Clinical Appointments tab

To support the accuracy of critical health information, records from health providers must be in the agency's possession when entering data on clinical appointments. If an appointment must be entered, any diagnoses identified by the medical practitioner during that appointment must also be entered.

The following information must be entered into this tab:

- Initial assessments in five domains (physical/medical, dental, developmental, mental health, and substance abuse for children 10 years of age and older) for any child who entered foster care within the 90 days prior to the date the district implements the Health Services Module, and every child who enters foster care thereafter;
- Periodic well-child care (physical/medical domain);
- Periodic preventive care (dental);
- "Immunizations up to date" indicator for initial and well-child physical/medical appointments;

- Discharge exam (use the “Well child” appointment type);
- The initial diagnosis of a chronic health condition. If diagnosed prior to entry into care, use the “Diagnosis at Intake” appointment type;
- All “Emergency Care” and “Crisis Intervention” appointments;
- Provider name and address for all appointments entered.

#### Early Intervention tab

The Early Intervention (EI) tab must be completed for any child under the age of three in an open Family Services Stage who was involved in an indicated CPS report. Unlike other parts of the Health Services Module, the EI tab is not subject to enhanced security. If the child receives an EI evaluation, record it as a developmental assessment in the Clinical Appointments tab in addition to completing applicable fields in the EI tab.

The following information must be entered into this tab:

- Early Intervention referral date for all children under 3 in an indicated CPS case;
- All other fields as applicable for referred children;
- Information on this tab must be entered prior to the child’s 4th birthday.

#### Bio Family Health Info tab

Health information on a parent or biological relative should be obtained from the health care provider pursuant to a release signed by the parent or person whose records are requested prior to entering this information into CONNECTIONS. If records cannot be obtained but the information is credible, enter it into the Bio Family Health tab. Put a brief note in the additional information box stating that documentation verifying the diagnosis could not be obtained and why the diagnosis is believed to be credible. Information on the HIV status of a family member should *not* be entered into CONNECTIONS.

The following information must be entered into this tab:

- Hereditary conditions and allergies of the child’s biological family;
- Information on the biological family’s health history that could impact the child’s current or future health;
- Information on the biological mother’s pregnancy for this child;
- Parent’s cause of death, if applicable. If the parent died as a result of HIV/AIDS, record the exact illness (e.g., Pneumonia) if known, or a general term such as Infectious Disease, if unknown.

#### HIV Risk Assessment

All children in foster care must be assessed for HIV risk, and the results of that assessment must be recorded on the HIV Risk Assessment tab. This tab is used for children in foster care *only*. The CONNECTIONS system does not

have a built-in system capability to limit access to confidential HIV-related information to only those persons authorized by statute to have access. Therefore, it is incumbent on the social services district or voluntary authorized agency to administer the system in a compliant manner. See additional information on HIV in the Confidentiality section above.

The following information must be entered into this tab:

- All risk assessments completed for children in foster care in accordance with OCFS regulation;
- All fields as prompted by system logic;
- Test date and results for Newborn Screening and confidential HIV tests.

#### Health Narrative

The Health Narrative may be used to record health information that is not appropriate to record in Progress Notes. This includes:

- Any information related to HIV/AIDS services;
- Quotes from the substance abuse provider's reports or notes;
- Quotes from mental health provider's reports or notes;
- Confidential reproductive health services, including STDs.

If the Health Services Module is not utilized for Preventive or open Child Protective cases, any health information (excluding HIV) related to the reason for the delivery of services by the respective child welfare agency *must* be documented in Progress Notes in CONNECTIONS. This information may include service for substance abuse, mental health, Early Intervention, or hospitalizations related to service needs or child protective issues. Given the highly sensitive nature of reproductive health services and STDs, it is recommended that this information *not* be entered into Progress Notes.

#### Recommended Actions

Maintenance of health-related information in the Health Services Module is *recommended* for:

- all children placed in the direct legal custody of relatives or other suitable persons under Article 10 of the Family Court Act (not in DSS legal custody);
- children served in open, indicated child protective services cases; and
- children served in child preventive services cases.

Health information related to children served through preventive or protective services *may* be maintained in the Health Services Module at the discretion of the social services district. Use of the Health Services Module for children receiving preventive services only through contract preventive agencies is at

the discretion and agreement or contract between a social services district and its contracted agencies. The same safeguards for sensitive information apply to these records.

A referral to the Early Intervention Program and subsequent entry of data into CONNECTIONS is recommended for:

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

## **B. Education Module**

Comparable to the Health Services Module, the Education Module provides an easily accessible location for documenting essential information related to a child's educational status. Documentation of relevant educational information is required for all children in foster care and youth in the custody of OCFS placed in a VA. The module supports easy identification of educational information about children; for example, what school they are in, if they have an Individualized Educational Plan (IEP), what special services they are receiving, surrogate parent information, and so on. In addition, it provides an historical view of the child's educational placements (e.g., how many schools the child was in, any special services provided to the child in previous schools, if the child repeated any grades, if she or he graduated, etc.). Similar to the Health Services Module, certain information entered into the Education Module will pre-fill to the PHR, if the pre-fill option is selected.

While much of a child's educational information must be recorded in the electronic case record, a hard copy of certain documents must still be maintained in the paper record and *must* include the information cited above (see 18 NYCRR 428.3) as well as copies of report cards, standardized test results, complete IEP reports and evaluations. All general information gathered from contacts with the school will continue to be recorded in Progress Notes. There is no narrative area in the Education Module.

Information can be recorded in the education module for children with no age limit, but remains applicable for foster children up to the age of 23. The upper age limit is derived from the federal Educational and Training Voucher (ETV) program funded through appropriations from the federal Promoting Safe and Stable Families Act of 2001 (Public Law 107-133) which makes such vouchers available to foster children and former foster children up to the age of 23.

The Education Module is available to all persons with a role or implied role in the case, and through the unit hierarchy. This ability to access the child's education information provides an opportunity for all persons serving the family to both view current information and, for those with a role in the case, add, modify and update the educational information, as needed. In addition, workers with a role in the current stage can view (but not change) education information that was recorded in a previous stage. Education information recorded in a previous stage is displayed in gray, except for the Child Case Record (CCR). If the child's current record was created in the CWS stage and carried over into the CCR stage, it will display without shading and is modifiable.

### **Legal Authority/Regulations Affecting Education Information**

According to OCFS regulation 18 NYCRR 441.13, agencies providing foster care services are responsible for:

- taking such steps as may be necessary to make certain that all children in care receive education appropriate to their needs and in accordance with the requirements of the Education Law;
- maintaining an active and direct liaison with any school in which a child in its care is enrolled; and
- making certain that each child in its care receives appropriate educational and vocational guidance.

For children in foster care, OCFS regulation 18 NYCRR 428.3(b)(2)(iii) requires that the uniform case record include 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 (CSE) evaluations and/or recommendations. It is recommended as a best practice that this information be recorded for all children removed under Article 10 of the Family Court Act and placed in the direct custody of a relative or other suitable person. Recording educational information is optional for children in receipt of preventive or protective services who are living at home with a parent or guardian.

Under federal law [section 475(1) of the Social Security Act], a case plan for a foster child must include the following:

- Names and addresses of educational providers;
- Grade level and performance;
- Child's school record;
- Services provided to a child.

For children in foster care or placed into the direct custody of a relative or other suitable person, education information and history has historically been

captured and maintained in the hard copy case file. Certain additional information has also been maintained in Progress Notes, under the Education Planning purpose.

### **Required Actions**

Current educational data must be entered into CONNECTIONS for:

- all children in foster care; and
- all children in OCFS custody placed with a VA (also included in the population referred to as “children in foster care”).

In addition, new school year information is expected to be entered each year by ***October 1*** and any changes to educational information should be entered into the system as close to the actual change as possible.

Information that must be documented includes:

- all applicable fields on the Education Detail window; and
- all applicable fields on the IEP window, including Disability, Service Types, Related Services, and Surrogate Parent.

Detailed, step-by-step instructions for maintaining data fields in the Education Module are contained in the **CONNECTIONS System Build 18.9 Job Aid: Education**.

Other information gathered from the schools and related to the child’s educational issues, educational needs or attendance must continue to be documented in Progress Notes. In addition, the federal Safe and Timely Placement of Foster Children of 2006 requires that foster children be given their educational records, to the extent available, (at no cost) when the child is discharged from foster care to their own care. The education record includes, among other things, the names and addresses of the child’s educational providers and the child’s grade level performance. (See 18 NYCRR 357.3(j))

Build 18.9.6 will create a new BF for the Education Module. In Build 18.9.7 this business function will support allowing a worker, primarily an education specialist without a role in the case, to record and view education information.

### **Recommended Actions**

If determined by the LDSS or VA as a best practice, educational information must also be entered for school age or pre-kindergarten children in direct custody of a relative or other suitable person (non-foster care) as certain information from Education can, at worker option, be made to pre-fill portions of the PHR.

The Education Module is optional for Preventive or Child Protective Services cases, but recommended for these service populations as well. VAs should

confer with the social services districts with which they contract about requirements to record education information. Being able to readily identify what school a child is attending and who the contact person is will assist every staff person associated with the case currently and in the future.

In order to provide for timely and accurate data entry, LDSS and VA staff should assess their current business processes regarding:

- whether information on children living at home who are in receipt of preventive and/or protective services will be supported in the Education Module;
- who is responsible for the entry and maintenance of this information;
- who is responsible for loading information on children currently in care;
- if departmental communication flow needs to be altered to allow for Education documentation to be entered into CONNECTIONS;
- if there are new CONNECTIONS users who may be responsible for the entry of Education information;
- if they have an existing system/database that can be replaced by CONNECTIONS;
- if they maintain two systems, how updates to both CONNECTIONS and an internal system/database will be achieved;
- how documents will be shared/passed from one department to another and if this will need to change.

### **C. Permanency Hearing Report**

The Governor's Permanency Law (Chapter 3 of the Laws of 2005) requires that a PHR be created and sent to required parties fourteen days prior to each and every permanency hearing date certain and that the report be filed with the Court. A Notice of Permanency Hearing with the date, time and location of the hearing must also be submitted or mailed to the required parties and a Statement to the Court of the Permanency Hearing Report and Notice Sent must be submitted to the Court, listing all those who received the PHR and/or the Notice. These documents were placed on the OCFS website as stand-alone templates when Chapter 3 went into effect. With the implementation of Build 18.9, the PHR, Notice and Statement are supported in CONNECTIONS.

It should be noted that permanency hearings and PHRs apply to the following children:

- children who have entered foster care as abused or neglected children (FCA Article 10);
- children who have entered foster care through a voluntary placement agreement (SSL §384-a);
- children in foster care who have been surrendered for adoption (SSL §383-c) and are completely legally free;

- children who have been surrendered for adoption (SSL §384);
- foster children determined by a court to be completely legally free for adoption, whether in foster care pursuant to FCA Articles 3 (juvenile delinquent), 7 (PINS), or 10 (abused/neglected), or by voluntary placement or surrender; and
- children placed by the court directly with a relative or other suitable person as an outcome of a FCA Article 10 proceeding.

[Note: While Chapter 3 of the Laws of 2005 does not expressly refer to Unaccompanied Refugee Minors, OCFS's position is that the standards of the new Article 10-A of the FCA relating to permanency hearings apply to such children in part in order to satisfy federal Title IV-E State Plan requirements whereby New York must afford procedural safeguards to all categories of foster children, irrespective of whether they receive Title IV-E funding.]

Chapter 3 of the Laws of 2005 does *not* apply to permanency hearings for persons in need of supervision (PINS) and juvenile delinquents (JD) in foster care who are *not* completely freed for adoption.

Each permanency hearing for children affected by this law will have a date certain established. Petitions for extension of placement and/or permanency hearings are no longer filed as a means to calendar the permanency hearing for this population. The term "date certain" means a specific day set by the court when a permanency hearing will be held. The date certain for the initial permanency hearing is set at the first removal hearing, or the hearing under section 358-a of the SSL approving the voluntary placement agreement or surrender. The date for each subsequent permanency hearing is set at the completion of the previous permanency hearing. The actual timing of the date certain is based on the standards set forth in section 1089 of the FCA:

- Initial Permanency Hearing (Non-freed Child)  
Date of removal from home plus 60 days plus 6 months = no later than 8 months;
- Initial Permanency Hearing (Completely Freed Child)  
Immediately following an approval of a surrender or termination of parental rights disposition; or no later than 30 days after the court hearing completely freeing the child;
- Subsequent Permanency Hearings (Freed and Non-freed Child)  
No later than 6 months following the preceding permanency hearing.

The Family Court has the authority to establish a date certain at an earlier date than the time frames listed above, since the statute requires the permanency hearing date to be set "no later than" each of the specified time frames. It should be noted that the date certain is to be entered in CCRS, as a modifier to the legal activity (Permanency Hearing) that is reported. This date is brought

over to CONNECTIONS. If necessary, it can be changed in CONNECTIONS, although any such change does not feed back to CCRS.

Notice of the Permanency Hearing and the Permanency Hearing Report under Article 10-A of the FCA must be provided to the following:

- the child's parent, including any non-respondent parent (see exception noted below);
- any other person legally responsible for the child;
- the foster parent in whose home the child currently resides, if applicable;
- the child's law guardian;
- the attorney for respondent parent, if applicable;
- the agency supervising the child's care, if applicable;
- any pre-adoptive parent; and
- any relative providing care for the child.

All former foster parents within whose home the child resided for a continuous period of 12 months must be provided *only with Notice of the Permanency Hearing*. This requirement is to be met regardless of whether the foster boarding home remains open or has since closed.

**Effective July 26, 2006**, Permanency Bill Technical Amendments - Chapter 437 of the Laws of 2006 did the following:

- Amended the notification provisions of section 1089 of the FCA to dispense with notification to the birth parent where the parental rights of the birth parent have been terminated or surrendered; and
- Permits the court to dispense with notification to a former foster parent where the court determines it is in the best interests of the child.

### **Overview of Permanency Hearing Report Module**

CONNECTIONS Build 18.9 provides workers with the ability to complete their obligations regarding the PHR, Notices and Statement, by utilizing functionality in CONNECTIONS. With Build 18.9, the worker's responsibility to fulfill statutory and regulatory requirements associated with date certain time frames as they apply to completion and submission of the PHR remains in effect as detailed in Article 10-A of the FCA. In addition, current models of practice related to contributors to the PHR continue with Build 18.9, as does the capacity for multiple workers with an assigned role in the case to contribute to the PHR. The PHR Module in CONNECTIONS utilizes the same content as the PHR Templates. The PHR templates continue to remain available on the OCFS website. Workers at ACS and voluntary

authorized agencies that contract with ACS will continue to use the Legal Tracking System (LTS) as an adjunct to the Module.

The PHR in CONNECTIONS is generated based on the child's permanency planning goal. It is presented in template format with Microsoft Word-like functionality available. There are three types of Permanency Hearing Reports:

- Individual child report;
- Multiple children in the same case who are not completely legally freed; and
- Individual child who is completely legally freed for adoption (available only in the Child Case Record (CCR)).

The Permanency Hearing Reports are integrated into CONNECTIONS and are accessible and easily navigable from the Permanency window. From that window, selecting a single child will automatically generate the Individual Child Report, unless that child is freed for adoption and in a CCR, in which case the Freed Child Report will be generated. Selecting multiple children in the same placement will automatically produce the Multiple Child Report. It is important to note that more than one PHR can be launched and in process within a stage; however, only one PHR can be in process at any one time per child (or children if PH-2 is being used for multiple children).

Use the Permanency Hearing Report for **Multiple Children (PH-2)** for children who are *not* completely free for adoption when:

- all children in the same family are scheduled to have a Permanency Hearing at the same time; and
- the children have at least one parent in common (but if any confidentiality concerns among parent recipients exist, use the Individual Report); and
- the children are placed together; if placed apart again consider confidentiality.

**Responses about each child must be individualized on the Multiple Children Report.**

Use the Permanency Hearing Report for **Individual Child (PH-1)** for a child who is *not* completely free for adoption when:

- a child is "partially free" and another child in the family is not free for adoption;
- *any* of the Multiple Children Report conditions are not met; or
- whenever it is equally or more convenient for the caseworker or the Court has directed an Individual Child Permanency Hearing Report be used.

Always use the Permanency Hearing Report for **Freed for Adoption Individual Child (PH-3)** for:

- each child completely legally free for adoption.

No address information about any of the participants in a permanency hearing (including the child's address), nor the child's school address information should be included in any Permanency Hearing Report. Concerning the inclusion of confidential HIV-related information in the Permanency Hearing Report, such information may be included *only* if all the persons with whom you are sharing the report are authorized under the Public Health Law to have access to such information.

Any worker with a role in the case can launch a PHR. He or she will next select either "pre-fill" or "no pre-fill." Demographic information and certain other data will populate the PHR and is not modifiable on the report, whether "pre-fill" or "no pre-fill" is selected. Selecting "pre-fill" will produce a document already populated with information from the Family Services Stage (most recent FASP, Plan Amendment, Removal Update, and the Health and Education modules), however some information will still need to be directly entered into the "pre-filled" PHR (particularly the Freed Child report). All information pre-filled in the template will be modifiable by the users (except for demographic information as noted previously). *If the worker selects the pre-fill option, it is critical that he or she review the information in the answer fields so that it will be appropriate and accurate. Editing will be required in almost every case.*

All contributors with a role in the stage are able to work in the PHR template within the system. The system will maintain a history of all Permanency Hearing Reports generated for each child in a stage.

A PHR may still be e-mailed, after being secured by password protection, to parties outside of CONNECTIONS, such as a LDSS attorney or supervisor. The PHR must be password protected in accordance with the instructions in the Guide for Caseworkers – Permanency Hearing Report, December 2005 and in keeping with "Security Guidelines for using Electronic Communication for Sharing Case Specific Information" located on the CONNECTIONS Intranet Security page. The Guide is accessible at:

<http://www.ocfs.state.ny.us/main/legal/legislation/permanency/Guide%20for%20Caseworkers-Permanency%20Hearing%20December%202005.doc>

In addition to the PHR, the Notices and Statements are also generated by the system. Court information necessary for these notices is entered in CONNECTIONS and the system will note when the document was generated; workers can note when they were mailed. A history is also kept on who they were sent to and when. Furthermore, other participants in the permanency hearing can be added to the Invitee List for the permanency hearing via the

“Add Other Participants” function (from the Stage Composition Options menu).

Build 18.9.7 will add additional functionality to the Permanency Hearing Module such that information about the petitioner can be added to the Court Information window, and that information will be pre-filled on the Notice.

### **Legally Freed Children**

For a child who has been legally freed and in a CCR, the Freed Child Report will be generated. The initial permanency hearing for a freed child must take place within 30 days of the hearing at which the child was legally freed. Many courts conduct the dispositional hearing and upon making the finding that a child is legally freed, move directly to the initial permanency hearing for the freed child. If the Family Court does not conduct the initial permanency hearing immediately following the dispositional hearing determining that a child is freed, there is the potential for a delay in the ability to auto-generate the correct PHR and submit that to the court and other parties within the specified time frames required by law. If the Court establishes the date certain for the initial permanency hearing for a completely freed child at the dispositional hearing, the child’s case is to be progressed to a CCR stage, thus allowing auto-generation of the correct PHR. If the Court does not establish the date certain for the initial permanency hearing after freeing, then the LDSS or VA staff must wait until receipt of notification of the date certain or court order legally freeing the child before they create the CCR.

Detailed, step-by-step instructions for creating and managing the PHR, Notice and Statement in CONNECTIONS are contained in the **CONNECTIONS System Build 18.9 Job Aid: Permanency Hearing Reports**.

### **Required Actions:**

- Once the PHR is launched, before staff take any further steps, they must check the demographics that are presented in the PHR template.
  - Data fields cannot be modified directly in the PHR; therefore, they will have to go to the original data entry source in the FSS and change the information there.
- All social services districts and VAs must confirm and review established guidelines and business processes regarding who will launch the PHR and who will complete what parts, because everyone who has a role in the case can “launch” the PHR, just like the FASP.
- Workers must keep the report in DRAFT until they are confident that material is complete and all required reviews have taken place, in accordance with any district/agency guidelines about PHR review. Social services districts and VAs are asked to review the implications of this for the review and approval process, and to decide who will make the decision that the PHR is complete.
- Each PHR must be reviewed for: cohesion, accuracy, currency, redundancy, and compliance with applicable confidentiality standards.

- Workers must delete any health information from a pre-filled PHR if it would become available to a person who does not have the legal authority to access such information, or if the consent of child is required but has not been granted to share certain information.
- After review is completed, the PHR is to be marked as final, freezing the report.

There may be circumstances where the use of the PHR templates outside of CONNECTIONS may still be needed. One example is a freed minor mom in foster care who has her own child with her. Currently, the CCR can only accommodate a single person, necessitating leaving the minor mom in the CWS, so an expanded payment can be made for the pair. The freed child PHR is only available from the CCR, necessitating use of the stand alone template. There may be other reasons as well.

#### **D. Security Changes**

##### **Recommendations:**

Management should carefully consider who receives those Business Functions listed in Appendix A and also refer to the **CONNECTIONS System Build 18.9 Job Aid: Health Services**, and Online Help within the Health Services Module for further detail.

Out assignments, in conjunction with Unit Hierarchy Access, should be carefully reviewed to protect the confidentiality of the information in the Health Services tab. Agencies should:

- Review agency assignments of the UNIT SUM ACCESS Business Function;
- Realign agency protocol regarding the assignment of the UNIT SUM ACCESS Business Function if needed;
- Remove the UNIT SUM ACCESS Business Function from those who should not have it;
- End date any staff that are no longer in need of CONNECTIONS access at all.

Persons who do not have a role in the stage and who should be updating health information for all children in a district or voluntary agency, such as a Nurse or other health care professional, should be given the MAINT HEALTH Business Function. The MAINT HEALTH business function, in conjunction with the CASE or CASE/PERS SEARCH Business Function allows users to update/view Health for all children for whom his/her agency has been designated responsible. Persons who need access to agency-wide health information but do not need to update health information should be given the

VIEW HEALTH BF in conjunction with ACCESS ALL AGY/DISTRICT BF. This might include administrators or Directors of Services.

### **E. AFCARS Data Elements**

Several of the required AFCARS elements are part of the Health and Education Modules. Primarily these are diagnoses which establish the child as disabled. It is essential that all such diagnoses be entered in the course of recording Initial Assessment, Reassessment and Well Child medical appointments. Any chronic condition for which credible information exists is to be entered as “diagnosis at intake.”

Modifications and enhancements will be made to CONNECTIONS in Build 18.9.6 that will further support compliance with federal AFCARS reporting requirements. Build 18.9.6, scheduled for implementation in spring of 2008, will contain modifications to include specific data elements related to placement and adoption services, including a new adoption related AFCARS window and additions to other windows for additionally required foster care data. Completion of these data fields will be required in order to meet AFCARS reporting needs for the first quarter of 2008. Most of these specific data elements relate to:

- Date of Removal
- Type of Legal Event Associated with Removal
- Conditions Associated with Child’s Removal

Examples of additional data elements that will be required are:

- Child Ever Adopted
- Has the child been previously adopted?
- Age (of child when previous adoption was recognized)
- How old was the child when the previous adoption was finalized?
- Was the child adopted internationally
- Foster family structure
- Child placed in Congregate Care

#### **Required Actions:**

All data elements must be completed effective with the date of implementation of the new functionality available in the CONNECTIONS application.

**IV. Effective Date:**

All requirements outlined in Health and Education are effective immediately. Priority should be given to entry of required fields in the Health Services Module, Clinical Appointments tab. This data must be entered by January 20, 2008 for all children in foster care in the custody of LDSS and OCFS as of December 1, 2007 or later. In relation to children receiving Preventive or Protective services only, all essential health and education information related to the reason for the receipt of child welfare services must be maintained in CONNECTIONS in either the Health or Education modules and/or in Progress notes. All relevant information must be maintained contemporaneously with the event and/or receipt of the information.

*/s/ Nancy W. Martinez*

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Issued By: Nancy W. Martinez  
Title: Director  
Office of Strategic Planning and Policy Development

Appendix A

NYS OFFICE OF CHILDREN AND FAMILY SERVICES  
BUILD 18.9 BUSINESS FUNCTIONS

Business Function	Security Attributes	Recommendations for Assignment	Description	Needed with Role	Needed without Role	Office Type
<b>MAINT APP REG</b>	Maintain App Reg	LDSS staff who are approved within their district to open a WMS Services Case from CONX.  Persons, who do not have a role in the stage and who are responsible for documenting/ updating health information and maintaining the medical history for all children in a district or agency; such as a Nurse, other health care professional, or care coordinator. Refer to the Health Services Job Aid for further detail.	Users with this BF will be able to initiate the application registration process in WMS for child welfare cases open in CONX.	Yes, if they are approved to open a WMS Services Case from CONX.	Yes, if they are approved to open a WMS Services Case from CONX.	LDSS
<b>MAINT HEALTH</b>	Maintain Health	Persons who need to access health information on a district or agency wide basis, such as an Administrator or Service Director who do not have a role in the stage, or access via unit summary. The BF must be assigned with the access all in district or agency BF to first gain access to the stage. The View Health BF allows them further access to Health information. Refer to the Health Services Job Aid for further detail.	Users with this BF may update/view Health information for all children for which his/her agency has been designated as having health care responsibility. Must be assigned the Case/Pers Such BF. BF allows access to the Health dialog via the Case Search path. No other dialogs are enabled.	No, not to access a child on their workload.	Yes, see Recommendations for Assignment	LDSS, VA, DRS
<b>VIEW HEALTH</b>	View Health	Persons who need to access health information on a district or agency wide basis, such as an Administrator or Service Director who do not have a role in the stage, or access via unit summary. The BF must be assigned with the access all in district or agency BF to first gain access to the stage. The View Health BF allows them further access to Health information. Refer to the Health Services Job Aid for further detail.	Users with this BF who also have the access all in district or agency BF may view health information for any child in a case where that district or agency has a role in the stage (or had a historical role in the case) and has or had been designated as responsible for updating the health information. For Implied Role. When accessing other FSS stages via Implied Role, the Health tab will only be enabled when the person in common is in any open INT, INV or ARI stage on the user's workload.	No, not to access a child on their workload.	Yes, see Recommendations for Assignment	LDSS, VA, DRS, RO, State

## Appendix B

The Job Aids referenced in this ADM and the Job Aid describing other functionality that became available with Build 18.9 are located on the CONNECTIONS intranet website by following the link below:

<http://ocfs.state.nyenet/connect/jobaides/jobaides.asp>

### Build 18.9 Job Aids

- [CONNECTIONS System Build 18.9 Job Aid: Health Services](#)
  - **Revisions:** [Health Services Job Aid](#)
- [CONNECTIONS System Build 18.9 Job Aid: Permanency Hearing Reports](#)
  - **Revisions:** [Permanency Hearing Reports Job Aid](#)
- [CONNECTIONS System Build 18.9 Job Aid: Critical Improvements](#) *(dated 4/5/07)*
  - **Revisions:** [Critical Improvement Job Aid](#)
- [CONNECTIONS System Build 18.9 Job Aid: Education](#)
  - **Revisions:** [Education Job Aid](#)

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 97 ADM-15

TO: Commissioners of  
 Social Services  
 Executive Directors of  
 Voluntary Authorized Agencies

DIVISION: Services and  
 Community  
 Development

DATE: July 24, 1997

SUBJECT: Foster Care: Assessment of Foster Children for Capacity to  
 Consent and HIV Risk; Counseling of Adolescents; Legal  
 Consent for HIV Testing; Documentation and Disclosure

-----  
 SUGGESTED

DISTRIBUTION: | Directors of Services  
 | Medical Services Staff  
 | AIDS Coordinators  
 | Staff Development Coordinators  
 | Foster Care Supervisors  
 | Legal Staff

CONTACT PERSON: | BRO - Linda Brown (716) 847-3145 USER ID: 89D421  
 | RRO - Linda Kurtz (716) 238-8201 USER ID: 0FH010  
 | SRO - Jack Klump (315) 423-1200 USER ID: 89W005  
 | ARO - William McLaughlin (518) 432-2751 ID: 0FN010  
 | MRO - Fred Levitan (212) 383-1788 USER ID: 72W035

ATTACHMENTS: | Listed in Table of Contents where those available on-  
 | line are so indicated

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
90 ADM-21	94 LCM-64	18 NYCRR	SSL 20	Standards	
91 ADM-36		Parts 357	34	of	
		428	373-a	Payment	
		441	398	Chap.VIII	
		507	PHL	(B)	
			Article		
			27-F		



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I. PURPOSE

The purpose of this directive is to provide guidance and set best practice standards for implementing New York State Department of Social Services regulations and policies requiring assessment of risk for human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS) in foster children. Included in this directive are guidelines for determining a foster child's capacity to consent and for obtaining legal consent for HIV testing when risk is identified.

Regulations requiring these actions were adopted and effective on August 23, 1995, amending sections 428.3, 441.22, and 507.2 of Title 18 NYCRR. New York State statutes related to these regulations include Public Health Law, Article 27-F, which establishes criteria for HIV-related testing and confidentiality; Section 373-a of the Social Services Law (SSL) which specifies the persons and entities to whom the medical history of the foster child must be provided; and Section 398(6) of the SSL, which requires local commissioners of social services to provide for expert mental and physical examinations of any foster child reasonably suspected of having a mental or physical disability or disease and to provide necessary medical or surgical care for any child needing such care. In addition, standards of care and treatment applying to residential programs for children must be provided according to SSL, Section 462.

II. BACKGROUND

As the number of HIV/AIDS infection and mortality cases continues to increase nationwide, the number of New York families and children infected and affected by the epidemic also continues to rise. While the highest statistics are reported by New York City, no area of the state is exempt from mounting numbers of cases of HIV infection. No vaccine and no cure for the disease has been developed as of the issuance of this directive. However, continuing research has resulted in development of new treatments and medications being used by the medical community to prolong life and maintain the quality of life for those infected. More effective early treatment makes the identification of children at risk more urgent and has resulted in the determination of the State Department of Social Services to develop this major policy initiative for the benefit of the children in foster care. The regulations emphasize the importance of preventive measures, counseling and education of youth and risk reduction, as well as testing when risk is identified, and medical care as needed.

The 1995 regulations were an important addition to previous requirements set forth in the Department's earlier Administrative Directive (91 ADM-36) issued September 16, 1991: "Foster Care and Adoption: HIV-Related Issues and Responsibilities." That directive focused on confidentiality and disclosure issues, documentation, and required training and information for staff involved in HIV-related issues, HIV counseling and testing.

The addition of the HIV assessment, counseling and testing regulatory requirements discussed in this directive continues the Department's efforts to address a health care crisis affecting families and children of all ages, with particular focus on children in foster care.

Chapter 220 of the Laws of 1996, which became effective February 1, 1997, required that all infants born in hospitals or birthing centers be tested for HIV. No parental consent for this additional component of the prior existing Newborn Screening Program is required. For a discussion of the significance of this testing in relation to an authorized agency's responsibilities, see page 10 of this directive.

### III. PROGRAM IMPLICATIONS

The regulatory requirement for assessment of HIV risk for each child placed in foster care, regardless of age, provides a higher standard of awareness and medical services related to the HIV epidemic affecting children and families in New York. Practice and program implications of this mandate will include development of new agency procedures for designation of informed staff to conduct assessments, obtain legal consents, arrange for HIV testing, provide follow-up services and ongoing counseling.

#### A. DESIGNATION OF STAFF TO MAKE ASSESSMENTS

Designation of staff to make the assessments of capacity to consent and HIV risk is an important internal administrative decision for each authorized agency. Such designations must include serious consideration of staff information and training on HIV/AIDS issues as required by Department regulations, as well as staff experience with particular age groups. Counseling and the ability to discuss prevention and risk reduction are skills needed by designated staff working with older children. When medical staff or a clinical social worker is available within the agency, such persons may be able to undertake the assessments with a minimum of additional preparation and training. Designated staff will need to use flexibility, cultural sensitivity, and their own experience and judgment in implementing assessment procedures, and modify those procedures based on the age, developmental stage and cognitive abilities of the foster child.

Staff designated to make the assessments should take advantage of further training opportunities offered through Department contractors, or through other agency, community or medical training providers, as discussed on page 20 of this directive. (Please also see pages 24 and 25 of 91 ADM-36 for agency requirements to provide HIV-related information and training for staff initially and annually.)

In addition to understanding the basic medical/physical development and impact of the disease, designated staff making the assessments of capacity to consent and HIV risk will need to learn the legal standard for capacity to consent as defined on page 5, as well as the rules regarding HIV-related confidentiality and the penalties for breaking such rules (see page 30 and Appendix A). The ability to relate to children in different stages of development and growth will be important in making the assessments, requiring sensitivity to the developmental and emotional status of each child. Ability to counsel adolescents will be a particularly important skill needed by staff designated to work with this age group.

B. FIRST STEP IN ASSESSMENT: DETERMINATION OF CAPACITY TO CONSENT

Determination of the foster child's capacity to consent is the first step for designated staff to take in meeting the requirements for assessment of HIV risk. No HIV testing, even after identification of risk, may take place unless written consent has been given by a person authorized to give consent according to Public Health Law, Article 27-F. A person with capacity to consent is the only person who may provide the required written informed consent before HIV testing may take place. For a child without such capacity, written consent for HIV testing must be obtained from a person authorized by law to give such consent (see pages 15-17 of this release).

An assessment of a child's capacity to consent is required by Department regulations within five business days of each child's entry into foster care. For each child who entered foster care prior to September 1, 1995, an assessment of capacity to consent was to have been made 60 days prior to the child's next medical examination or to the next service plan review occurring after August 23, 1995, whichever was earlier.

1. Alternatives and definitions

Staff designated to determine the child's capacity to consent are required to consider in their initial five day assessment which of the following two alternatives applies to the child: (1) there is NO POSSIBILITY that the child has the capacity to consent, or (2) there may be A POSSIBILITY that the child has the capacity to consent. In the case of the second category, staff have 30 days to make a final determination regarding the child's capacity to consent. The determination regarding which

category applies to the child must be made without specific regard to the child's age, and the decision must be based on the definition of capacity to consent provided in Article 27 F of the Public Health Law and included in Department regulations at section 441.22 (b) (1) as follows:

+++++

CAPACITY TO CONSENT

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.

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Decisions regarding capacity to consent are to be made on a case-by-case basis, with consideration given to the developmental stage and cognitive abilities of the child.

"Cognitive abilities" refers to a child's level of perception, memory, judgment, and understanding as these characteristics relate to HIV risk factors, risk behavior reduction, HIV testing, counseling on the nature and consequences of the disease, and the disclosure of HIV-related testing information.

In cases where a designated staff person has difficulty making a satisfactory determination regarding an individual child's capacity to consent, supervisory assistance is recommended. In rare instances when the decision is not resolved with supervisory assistance, consultation with a third professional may be necessary.

2. Assessment Categories

While the definition of capacity to consent prohibits determination based on specific age, the application of the definition to children in foster care requires an assessment based on realistic levels of development and cognitive abilities. The following assessment categories provide best practice guidelines for making the determination:

a. Infants and pre-school children

Infants and pre-school children entering foster care would clearly have NO possibility of capacity to consent, based on the legal definition given above. In such cases,

designated staff are to proceed immediately with the assessment of risk for HIV infection described in Section III. C. beginning on page 7. For those children with NO possibility of capacity to consent, the HIV risk assessment, based on medical or psychosocial information available at the time, must also be completed within the first five business days of entry into care. Children in this category who entered foster care prior to September 1, 1995 were to have an assessment of capacity to consent and HIV risk 60 days prior to their next periodic medical examination or service plan review, whichever came earlier.

In cases where an infant or pre-school child has already been tested through the Department of Health mandated universal newborn testing program effective February 1, 1997, and the results of such test are made available to the authorized agency, documentation of any known risk and results of the HIV testing at birth are to be included in the child's uniform case record. This information will need to be shared with the child's medical provider at the time of the comprehensive physical examination required within 30 days of the child's entry into foster care.

b. Elementary school children

A foster child in this category would generally have NO possibility of capacity to consent, particularly if the child is in the lower elementary grades. It is unlikely that a child under the age of puberty would be fully able to understand and appreciate the nature of this complex disease or to make an informed decision regarding testing and disclosure. Only in exceptional cases might such a child be considered to have A possibility of capacity to consent. (The fact that a child is assessed to have no capacity to consent does not eliminate consideration of informing and counseling an elementary school child regarding prevention and risk reduction at a level appropriate for the age and development of the child.)

Further, since capacity to consent is to be determined on a case-by-case basis, if there may be A possibility of such capacity, staff may take up to 30 days after the child's entry into care to make a firm decision and to complete the HIV risk assessment. For elementary school children who entered foster care prior to September 1, 1995, determination of capacity to consent and assessment of risk for HIV infection were required no later than 60 days before the child's next periodic medical examination or service plan review, whichever came earlier.

c. Pre-adolescent, early adolescent middle school children

Foster children attending middle school or junior high school are more likely to have the capacity to consent

based on the legal definition. However, the broad range in individual physical, mental and emotional development in children at this stage of growth requires a case-by-case determination of such capacity within the 30 day timeframe allowed by the regulations when there may be A possibility of capacity to consent. In this developmental stage, supervisory review of the determination of capacity is suggested, and where a question remains, consultation with a third party may be necessary.

d. High school and post-high school youth

Young people in these categories will generally have the capacity to consent to HIV testing and disclosure, although there may be exceptions in cases of developmental delay or disability and/or mental or emotional instability. In most cases, through the required information and counseling process within the 30 day timeframe for determination of capacity and assessment of risk, adolescents and young adults will be able to understand and appreciate the nature and consequences of the disease and to make an informed decision regarding the recommended testing when risk is identified.

Unresolved questions regarding capacity to consent in this stage of development should be referred to a supervisor and may suggest the need for consultation with other appropriate professional staff, such as a psychologist or clinical social worker.

When a youth in foster care is determined by staff on the basis of developmental stage and cognitive abilities to have the capacity to consent, that young person has the right to make his or her own decision on whether to be tested for HIV infection.

C. SECOND STEP: RISK ASSESSMENT FOR HIV INFECTION

1. Required timeframes for HIV risk assessment

The second step in the requirements for HIV assessment and testing involving children in foster care is the determination of HIV risk factors in the child's medical and psychosocial history, based on the information available. For children with NO possibility of capacity to consent, the assessment of HIV risk must be completed within the first five business days of entry into care. If agency staff determine that a child may have A possibility of capacity to consent, the timeframe for both the determination of capacity to consent and the HIV risk assessment is extended to 30 days from entry into care.

For each child who entered foster care prior to September 1, 1995, determination of capacity to consent and assessment of HIV risk were to be completed 60 days prior to the child's next

service plan review or next scheduled medical examination, whichever came earlier.

## 2. HIV risk factors

Three groups of HIV risk factors for use during the assessment process are provided in the Department's regulations (section 441.22(b) of 18 NYCRR) and in Section IV.D. (pages 23-24) of this directive. Developed with the cooperation of the medical community and the AIDS Institute of the Department of Health, the listed factors are to be used by designated staff in reviewing the health/medical and psychosocial history and other written records regarding the child, as well as for guidance in discussions as appropriate with a child, youth or child's parents. The risk factors should never be used as an oral checklist with children, but are intended primarily for internal use by staff in making the assessments.

The first group of risk factors is relevant for an assessment of infants and pre-school children, with the factors related to perinatal transmission from the mother to the infant during pregnancy, at birth or through breast-feeding. The second group, a list of family psychosocial/health factors which also may result in perinatal HIV transmission, is primarily related to infants and pre-school children, but has been identified as a latent source of transmission to some elementary and middle school children as well.

The third group provides a list of factors primarily used for assessment of older children, based on the child's behavior and/or other means of direct transmission. (See further discussion on pages 23-24.) It is this third group which may be helpful in counseling and discussions on prevention and risk reduction with older youth who may be able to understand the serious issues involved in transmission of HIV/AIDS.

## 3. Assessment of HIV risk through written records

For all age groups, the health/medical and psychosocial family history of the child, to the extent available, is the foundation for the assessment of HIV risk. Therefore, a review of any written information/records concerning the child is essential. Information regarding the child or child's family may be available through the following:

- a. any medical or psychosocial records available at the time of placement or that become available at any time while the child is in foster care;
- b. any relevant information recorded as a result of contacts and discussions with the child's family, foster family, or medical providers;

c. child protective services investigative reports on the Preliminary Assessment of Safety form (DSS 4337) or other written record.

When a child is identified through such available information as having one or more of the HIV risk factors listed on pages 23 and 24 of this directive, the risk factor(s) and basis for the determination are to be documented in the uniform case record of the child. Authorized agencies must keep all HIV-related information in the medical history file of the child which is technically part of the uniform case record, but is often kept in a separate location in order to limit access to specified persons.

When a review of the information available is insufficient to determine whether a child is at risk, staff will need to make a reassessment when new information becomes available. In all cases, staff will need to review any additional relevant information at each service plan review and each periodic medical examination of a child that occurs after the initial assessment of the child pursuant to Section 441.22(b)(6) of Department regulations.

4. Assessment of HIV risk indicating direct, person-to-person discussion/contact

The following guidelines for assessment of HIV risk involving person-to-person contacts, discussion and counseling, as appropriate, are provided in the same four categories as those used above to determine capacity to consent:

a. Infants and pre-school children

Available written records of the child in this category will generally be sufficient to make an assessment of HIV risk. However, if relevant information is lacking, designated staff may wish to make reasonable efforts to contact the parents of the child, other staff, medical or community services providers who are known to have knowledge of the child and/or the child's family.

It is this category of child for whom early intervention and medical treatment have been determined through scientific studies to be extremely important in maintaining the quality of life and prolonging life. The identification and medical care of infants and pre-school children who may be HIV-infected are therefore urgent goals of the Department's assessment and testing policy and regulations. If one or more risk factors are identified for a child in this category, immediate efforts should be

made to obtain necessary legal consent for testing or re-testing as necessary and to arrange for the test so that early treatment and services may be provided if the child tests positive.

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Virtually all children born in the State since February 1, 1997 are tested for HIV antibodies shortly after birth as part of the State's Newborn Screening Program (NSP). The authorized agency should not retest a child under the age of twelve months unless the child tests negative at birth but there are risk factors that are present after birth (i.e., the infant has been breast fed); the authorized agency is unable to obtain the NSP test results; or the child's NSP test was positive necessitating follow-up PCR or viral culture testing discussed below. Additionally, given the availability of the test results, as described below, authorized agencies should seek the test results for all foster children born on or after 2/1/97, up to the age of 12 months, regardless of whether or not there are risk factors present. The test results should be available approximately ten days after the child's birth.

There are two possible methods for obtaining the test results, both of which require obtaining one of the following identifiers: a) the Newborn Screening Program Blood Collection form identification number (available from the birth hospital through the Newborn Screening Designee; however, after a couple weeks following birth may only be available through the hospital's medical records office which, depending upon the hospital, may take too long a period to be made available to be viable); or b) the mother's social security number.

A physician caring for the foster child can access the newborn test results through the NSP's Voice Response System (VRS) at Wadsworth Laboratory, using one of the two identifiers described above. (Note: All physicians must register with the NSP at (518) 473-7552 if they have not used the system before.) If the authorized agency does not find this method of obtaining the test results practicable for a particular child, the agency can instead contact the ACS Pediatric AIDS Unit (212) 266-3304, if the child is in ACS' custody, or Carol Shortsleeves from this Department at (518) 474-9594. If you choose to use the ACS or NYSDSS contact person, it will still be necessary to have one of the two identifiers listed in the preceding paragraph. The ACS and NYSDSS will then contact the State Department of Health (SDOH) Laboratory to obtain the test result. (SDOH will be evaluating the volume of requests it receives for test results from ACS and NYSDSS to determine its ongoing

capacity to provide results for foster children up to the age of 12 months.)

The newborn's antibody test results reflect the HIV status of the mother. A negative result means the mother and newborn are most likely not infected. A positive result means the mother is infected and the newborn may or may not be infected. To determine if the newborn is infected, a child must be retested using a more sophisticated "PCR" test (or viral culture). All infants will need at least two PCR tests. The optimal time for the first PCR is at the first pediatric visit or by one month of age. HIV infection can be reasonably ruled out for infants who have had two negative PCR tests after one month of age, with one test coming after 4-6 months of age. (The SDOH does HIV PCR testing on all HIV positive infants less than 18 months of age for free.) The SDOH requires the birth hospital to notify the physician responsible for the baby's care of the antibody test results. If the result is positive, the physician must administer the follow-up PCR test(s) and provide or arrange for post-test counseling for the infant's mother. Any PCR test required to be administered to an HIV-antibody positive infant up to the age of 12 months born on or after 2/1/97 does not require the obtaining of legal consent.

The SDOH requires birth hospitals to ensure that an infant who tests HIV-antibody positive on the Newborn Screening test is located and has a definitive diagnosis by PCR (or viral culture). The hospital is also required to obtain the results of the PCR test (or viral culture). It is important to determine those infants who are infected so they can receive early care, including drugs to prevent PCP (a serious form of pneumonia to which very young HIV-infected infants are particularly susceptible).

There may be occasions when a child tests HIV-antibody positive, enters foster care shortly after birth, and the birth hospital (or the SDOH, if the hospital asks for assistance) is trying to locate either or both the infant and the mother. In relation to the infant, the authorized agency should provide the following information, upon request, to the birth hospital or the SDOH:

- (1) the location of the infant;
- (2) the name and phone number of the physician/clinic caring for the infant;
- (3) whether a PCR (or viral culture) is scheduled for the infant or has been done; and
- (4) the results of such testing.

If the birth hospital or the SDOH asks for assistance in locating the infant's mother, it is for the purpose of informing her of the test result, providing counseling, and

encouraging her to receive appropriate medical care, especially if she was previously unaware of her HIV positive status. If the case planner knows the whereabouts of the infant's mother or is in contact with her, he/she should tell the infant's mother that they have been asked to inform her that she should contact the birth hospital to obtain important medical information about herself. After making such contact as soon as practicable, the case planner should inform the entity trying to locate the infant's mother that the message was conveyed.

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b. Elementary school children

Written records and reports should serve as the foundation for the assessment of HIV risk in this category of children. Relevant risk factors will be found primarily in the first two groups of factors listed on pages 23 and 24, involving perinatal transmission of HIV.

However, staff should be aware that some items in the third group (e.g., sexual abuse), may also be applicable to elementary school (and pre-school) children. After checking the written records available, a designated staff person with experience and ability in relating to this category of children may wish to initiate a discussion with the child as appropriate about HIV risk behavior and the reasons for the assessment and possible testing.

The approach used in such discussions will depend on the developmental and emotional status of the child and the ability of the child to understand such explanations. For example, a child may be among those children who have already been involved in substance abuse or in sexual activity. If there is any indication of such risk behavior, and if the child appears able to engage in a discussion of prevention issues, the staff should begin such a discussion and provide opportunities to continue on other occasions.

In many cases in this category, designated staff may be able to discuss with the child who has one or more risk factors the importance of the HIV test in order to provide any necessary medical care. It should be explained to the child that the test will probably involve drawing blood, but will be no more painful than, for example, the types of required injections the child has experienced to protect against disease -- the required pre-school vaccinations.

While the older child in this category may be determined to have capacity to consent as defined in section III.C., most of these children will probably not meet the standard. Therefore, if one or more HIV risk factors are identified, and the child is determined not to have the capacity to

consent, staff will need to obtain the necessary legal consent for HIV testing from someone other than the child and arrange for the test according to procedures described in paragraph III.D. below.

c. Pre-adolescent, early adolescent middle school children

Many children in this category may meet the standards of development and cognitive ability leading to a determination of capacity to consent. HIV risk assessments involving children at this level should be made by staff who are well-informed regarding HIV/AIDS issues and have training and experience in working with children in this category.

While a review of written records will again serve as the basis for an initial assessment of risk, staff must initiate a person-to-person discussion with each youth within the first 30 days of entry into foster care in order to complete a determination of capacity to consent and a valid assessment of HIV risk.

Staff should take care to ensure that the initial and subsequent meetings of staff with the child regarding HIV risk be non-confrontational and non-threatening. Again, the risk factors listed in Section IV. D. of this directive should not be used as an oral checklist in assessment and counseling meetings with children and youth. The list is intended as a guide for staff in reviewing records and discussing prevention, risk reduction, and transmission of the disease with children and youth as appropriate for their level of understanding.

Risk factors particularly relevant to this category of child will be those in the third group on page 24 related to direct transmission of HIV through personal contact involving blood or semen, although perinatal transmission has been documented as the risk factor in some cases. Discussion of the third group of factors can form the basis for providing important information and counseling to the child. The initial meeting will be important in helping the child understand the reasons for the required assessment of HIV risk in order to offer support services and medical care if needed. Continuing opportunities for sharing information should be offered. If risk is identified, other issues for discussion will include required information on confidentiality and disclosure as discussed on page 30 of this directive.

d. High school and post-high school youth

As with the middle school category above, the initial meeting with high school youth will be important in helping the youth understand that the required HIV risk assessment

and discussion are meant to offer opportunities for sharing information on prevention and reduction of risk behavior, as well as to provide a recommendation for testing if risk is identified.

As is true for the pre-adolescent children, staff working with this category of youth will need to be sensitive and flexible in providing opportunities for such counseling and discussion and to understand that the young person may be both emotionally and physically exhausted by the events which have led to placement in foster care. At no time should such meetings become threatening, confrontational, or coercive.

The risk factors particularly relevant to high school and post-high school youth are those on page 24 related to direct transmission of HIV from another person, generally through the youth's own behavior, particularly related to sexual activity or drug abuse. Other possible risk factors are sexual abuse and, very rarely today, contaminated blood transfusions. Prior to discussions and counseling sessions with the youth, staff will need to review any information available through CPS, medical history, or other documentation related to possible HIV risk.

If the youth has the capacity to consent and is identified through the HIV risk assessment as having one or more risk factors, staff will recommend testing and discuss with the youth the reasons why such a test is important in order to obtain medical and other services if the result is positive. In addition to a discussion of the identified risk and the recommendation for testing, staff will need to forthrightly discuss the issues of confidentiality and disclosure as they apply to foster children (see page 30), as well as explaining to the youth the two types of testing available -- confidential and anonymous -- and the differences between the two. The youth with capacity to consent then has the absolute right to make his or her own decision regarding whether to undergo HIV testing and, if so, the type of testing.

In confidential testing of children in foster care, the name of the child and the authorized social services agency with responsibility for the child are recorded by the test site, and the results of the test are to be provided to the agency, as well as to others specifically permitted by law to be given such information as discussed on pages 30-32.

Anonymous testing is available in certain locations only to persons with capacity to consent. The person tested is identified only by an ID number. Results of the test can be given only to that person, regardless of foster care

status. However, a recent Department of Health policy change allows the person who chooses the anonymous type of testing to request a conversion from anonymous to confidential status at the time the results are provided. This makes possible the transmission of the results to a medical or social services provider in order to obtain needed treatment or services.

As in all categories, documentation in the case record will be necessary on the assessment of capacity to consent, assessment of HIV risk, counseling provided, and in the case of youth with capacity to consent, the decision regarding testing and arrangements made for the test if consent is obtained.

D. THIRD STEP: OBTAINING LEGAL CONSENT FOR TESTING

When HIV risk has been identified, designated staff will need to obtain legal written consent from an individual with legal authority to consent before the child can be tested.

1. Child with capacity to consent

As indicated on the preceding page, the child or youth who has been determined to have capacity to consent is the only person who can make a decision regarding testing and provide legal written consent for his or her HIV test.

If the youth agrees to be tested, he or she will be asked to sign a brief dated statement of consent (see model form in Appendix D) to be retained in the case file. (Please note that this brief statement is for the social services agency record; at the testing site, the youth will be asked to sign the Department of Health official informed consent form (see Appendix E for official form).) Staff will then proceed to make arrangements for the test within the next 30 days.

2. Child without capacity to consent

When a foster child does not have capacity to consent, there are three possible sources, all with specific limitations, for the necessary legal consent for the HIV testing of the child:

0 - the parent or legal guardian of the child; or

0 - the local social services commissioner or designated representative on an administrative level; or

0 - a court order in cases of urgent medical necessity as defined on page 16-17.

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FOSTER PARENTS OR PROSPECTIVE ADOPTIVE PARENTS MAY NEVER PROVIDE LEGAL CONSENT FOR TESTING OF A FOSTER CHILD. CASEWORKERS MAY NEVER PROVIDE LEGAL CONSENT FOR TESTING OF A FOSTER CHILD.

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a. Consent by the parent or legal guardian of the child

(1) When HIV risk has been identified for a child without capacity to consent, and the child has been taken into custody under Article 10 as an abused or maltreated child, 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 SSL or section 1022, 1024, or 1027 of the FCA, it is necessary to discuss with the parent or guardian the child's risk and the need for testing. Staff need to ask the parent/guardian for permission to test the child and to ask for a written response within 10 days of the request. If the parent agrees to provide legal consent for the test and is able to be present at the test site with the child to sign the required Department of Health pre-test consent form, staff should schedule the appointment and make other arrangements, including transportation as necessary.

If the parent refuses or is unable to provide written permission for testing the child identified as being at risk for HIV after reasonable efforts have been made to contact and discuss the importance of testing, it will be the responsibility of the commissioner or designated representative to provide the legal consent for testing in Article 10 cases.

(2) When HIV risk has been identified for a child without capacity to consent, and the child has been placed in foster care voluntarily by the parent/guardian, or has been placed in foster care as a Person in Need of Supervision (PINS) or as a Juvenile Delinquent (JD), written parental consent is required in order to test the child. If the parent refuses to provide such consent, staff are encouraged to meet with the parent to discuss the importance of early treatment and care for children who may be HIV-infected. If the parent continues to refuse, the authorized agency's only alternative in such cases is to determine whether to ask for a court order, pursuant to FCA 233, based on urgent medical necessity as defined below.

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Urgent medical necessity, for the purpose of this directive, means a determination that:

- (1) a child entering care has previously tested positive and/or has symptoms related to HIV infection requiring immediate medical attention; or
- (2) the infant or pre-school child has been abandoned; or
- (3) the child's parent has HIV/AIDS or has died from HIV/ AIDS.

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b. Consent by the local social services commissioner or designated representative.

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"Designated representative" refers to designation by the local social services commissioner of specific staff on an administrative level within the agency or in a contract agency to provide written consent on behalf of the commissioner in appropriate cases; for example, a deputy commissioner, director of services, or the executive director of a voluntary child caring agency.

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(1) When HIV risk has been identified for a child without capacity to consent, and the parents of the child have surrendered guardianship and custody of the child or parental rights have been terminated, the local social services commissioner or designated representative must provide the necessary written consent for testing the child. Designated staff will need to obtain the signed consent and make arrangements for the test.

(2) When HIV risk has been identified for a child without capacity to consent, and the child has been taken into or kept in protective custody pursuant to Article 10 of the FCA or section 417 of the SSL, and the parents are unavailable or have refused to provide consent for the child to be tested, the local social services commissioner or designated representative will provide the necessary written consent, as explained in a. above.

E. FOURTH STEP: HIV COUNSELING

1. Counseling required by Public Health Law

Article 27-F of the Public Health Law requires that the person who provides written consent for the HIV test must receive pre- and post-test counseling and information regarding the test at the test site. This rule is applicable to the child with capacity to consent and to the parent or guardian who accompanies the child without capacity to consent to the test site.

However, such a rule would not be applicable to a physician who provides consent in an emergency situation, nor to the social services commissioner with custody of the child, nor to the commissioner's designated representative with the legal right to sign the required consent form prior to an HIV test for foster children without capacity to consent. Again, caseworkers or foster parents who accompany a child to a test site may not sign consent for the child's testing, but should carry with them the required consent form signed by the appropriate person. They may be asked by site personnel to receive such pre- and post-test counseling as is appropriate.

Counseling and information provided at the test site are governed by the requirements of the New York State Department of Health, and will include an overview of the following as appropriate for the child to be tested and/or the adults present:

- a. the HIV test, including its purpose, the meaning of the results, and the benefits of early diagnosis and medical intervention;
- b. the procedures to be followed, including that the test is voluntary for persons with capacity to consent; that consent may be withdrawn at any time by a person with capacity to consent; and that anonymous testing is available for persons with capacity to consent;
- c. the persons entitled to disclosure of HIV-related information according to Public Health Law;

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(Please note that this information may be confusing unless the foster child, parent or guardian, foster parent, or caseworker present at the testing site has been previously informed regarding confidentiality and disclosure issues under Social Services Law and regulations, which differ from and add to the basic requirements in Public Health Law.)

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- d. the nature of AIDS and HIV-related illness, information about discrimination problems and the legal protections against such discrimination, and information about risk behavior for transmission/contraction of HIV infection;
- e. referral to an anonymous testing site upon request of a child with capacity to consent.

These Public Health Law requirements in no way replace the responsibility for authorized agencies providing foster care to

meet the assessment and counseling requirements set forth in Department regulations and this directive.

2. Counseling required by social services policy and regulations

Social services agency staff need to ensure that foster children and youth, parents or legal guardian, foster and prospective adoptive parents, as applicable, are prepared and informed prior to the child's testing site visit. When the test is conducted in-house, qualified and licensed medical employees of the authorized agency may be designated by the administration to provide the information and counseling needed to meet both Public Health Law and social services requirements. However, if the testing site is external to the agency, the staff there will provide standard information as required, but may have no familiarity with the child's background or medical history and no reason to develop a continuing relationship with the child. Therefore, the PHL counseling procedure will not negate the foster care agency's responsibility to maintain a counseling relationship with the child, especially with adolescents.

One of the most difficult and critical challenges of the HIV assessment and testing policy is the need for staff to provide information and counseling to pre-adolescent and adolescent foster youth on HIV prevention and risk reduction as required by section 441.22(b)(4)(i)(h) of Department regulations and this directive. Department-contracted training for staff on "Adolescents and AIDS" is available to prepare staff for this responsibility, as are a variety of materials from the Department of Health and community organizations. Any combination of individual and group discussions, booklets, pamphlets and other print materials, videos, peer support groups, peer theater productions or other means of communication, as well as directed counseling, may be useful in gaining the young person's attention regarding the importance of HIV prevention and risk reduction. Medical centers and youth-serving organizations in urban areas are often resources for this essential service.

In all cases, the youth with capacity to consent must be informed by designated staff of any risk factors identified for him or her, and the importance of being tested in order to receive medical care and services if HIV-infected. In addition to being offered the choice of confidential or anonymous testing as described on pages 14 and 15, the youth should be fully informed as to the confidentiality and disclosure rules required by Social Services Law; for example, the requirement that agencies inform the child's foster or prospective adoptive parents of all known medical issues, including HIV-related information concerning the child, as discussed on pages 31 and 32.

Along with discussion of the risk assessment and information regarding an HIV test, designated staff working with children

who have any possibility of capacity to consent should ensure that they have ongoing opportunities for access to further information and discussion.

F. TRAINING, INFORMATION AND SUPPORT FOR STAFF AND FAMILIES PROVIDING SERVICES RELATED TO HIV ASSESSMENT, TESTING AND CARE OF AT RISK FOSTER CHILDREN

Every authorized agency will need to develop a plan to provide or arrange for the training, information and support necessary for all persons involved in the HIV-related assessment, testing and care of at risk foster children.

1. Information and training for staff

All staff who are given access to confidential HIV-related information will need information and training within 45 days of employment on basic medical, legal and service issues related to the HIV risk assessment and testing of foster and adoptive children. In addition, annual updates on such issues will ensure that information is provided on continuing changes in medical care and legal procedures. Such information may be provided through any combination of formal training, informal discussion and informative materials, so long as all topics required by Section 431.7(c) of Department regulations are covered.

Basic and advanced AIDS training for agency staff is provided by the Department under contract with qualified organizations. In addition, other state agencies, including the Department of Health, as well as many urban medical centers and community service providers, offer conferences, forums, and classes related to HIV/AIDS issues.

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Please refer to Administrative Directive 91 ADM-36, "Foster Care and Adoption: HIV-Related Issues and Responsibilities," pages 16, 24-25 for more detailed discussion of training issues. For additional resources, see Appendices attached to this directive for possible contacts, consult your agency's staff development coordinator, or contact your Regional Office for further information on available training.

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Some agencies working with HIV-affected children and families have found that support groups for staff have been effective in helping them cope with the emotional stress involved in providing services to this population. In many communities, networks of HIV/AIDS service providers offer mutual support activities. Appendices attached to this directive suggest contacts.

2. Foster parent support and training

Foster parents caring for HIV-infected children should also be

encouraged to take advantage of any educational opportunities provided by the agency or through the wider community to develop greater understanding of this complex disease and the skills necessary to support such children. Basic and advanced AIDS training for foster parents is provided by Department contractors.

If the child is designated as a "special" case, the foster parents must meet an annual training requirement of four hours in order to receive an enhanced (special) maintenance payment. If the child is designated as an "exceptional" case requiring a high level of care, foster parents must meet an annual training requirement of five hours in order to receive an exceptional maintenance payment. (See section 427.6 of Department regulations or the Standards of Payment Manual, Chapter VIII (B).)

#### IV. REQUIRED ACTION

Authorized agencies are required to take the following actions related to HIV risk assessment of all foster children and to HIV testing when appropriate:

##### A. DESIGNATION OF STAFF RESPONSIBLE FOR ASSESSMENTS OF CAPACITY TO CONSENT AND RISK OF HIV INFECTION

1. Each authorized agency must designate staff with appropriate background, training and experience to make the required assessment of each foster child's capacity to consent and risk of HIV infection. Such staff persons may be caseworkers, supervisors, clinical social workers, or medical personnel.

2. Qualifications of staff designated to make HIV risk assessments must include:

- a. participation in HIV-related training; or
- b. knowledge of HIV confidentiality requirements.

##### B. REQUIRED TIMEFRAMES FOR ASSESSMENTS OF CAPACITY TO CONSENT AND HIV RISK

1. Within five days of entering foster care, each child, regardless of age, must be assessed for capacity to consent as defined in Public Health Law and on page 5 of this directive.

A determination must be made and documented by designated staff within each authorized agency as to whether there is no possibility that the child has the capacity to consent or whether it is possible that the child may have the capacity to consent to HIV-related testing.

2. If a child is determined to have no possibility of capacity to consent, an assessment of risk for HIV infection must also be

determined within the first five days of entering care and documented as described beginning on page 7.

3. If it is determined that it is possible that a child may have the capacity to consent, an informed decision must be made and documented within 30 days of the child's entry into care regarding such capacity, and an assessment of risk for HIV infection must also be determined within the 30 day timeframe as described beginning on page 7.

4. For children entering care prior to September 1, 1995, all such children were required to be assessed for capacity to consent and risk of HIV infection at least 60 business days prior to the children's next scheduled periodic medical examination, as indicated in section 421.22 of Department regulations, or at least 60 business days prior to the children's next required service plan review, whichever occurred first.

C. BASIS FOR ASSESSMENT OF HIV RISK

1. For the child determined within five days of entry into foster care to have no capacity to consent, the child must, within the same five day period, immediately be assessed for risk of HIV infection based on the available medical and psychosocial history of the child, whether documented in a Child Protective Services (CPS) report, preventive services or other records, or provided orally by the child, parent, caseworker, or medical provider.

2. When it is determined within five days of entry into care that a child may have capacity to consent, such determination of capacity to consent must be made within 30 days. The child also must be assessed for risk of HIV infection within that 30 day timeframe, using available medical and psychosocial history of the child as documented in reports and records, and through oral discussions with the child or medical provider as appropriate.

Oral assessments and counseling of the child must be conducted as appropriate for the age and development of the child, as discussed in Section III of this directive. Such discussions with the child must never be confrontational or threatening in any way. The second group of risk factors involving family members should not be used as an oral checklist with a child.

3. Assessments must be based on the risk factors listed on pages 23 and 24.

4. Results of the assessment must be documented in the child's medical record section of the uniform case record, with any risk factors identified. If no risk factors are identified, documentation in the uniform case record must specify that an assessment has been completed as required and must record the

date of the assessment. If the risk assessment for infants or very young children cannot be completed within required timeframes because of an emergency placement with no medical or social history of the child available, dated documentation in the case record must state that fact, along with a plan for obtaining such history. However, please note in the risk factors in section IV. D that abandonment is a valid risk factor, and also, as stated in C.1 above, a review of a CPS report or preventive services record may establish risk.

#### D. HIV RISK FACTORS

There are three groups of risk factors that must be used as the basis for determining whether the foster child or youth is at risk for HIV infection. The first two groups are primarily applicable to infants or young children who may have been infected at birth. The third group is primarily applicable based on the personal behavior of older children and adolescents, although there are important exceptions, such as sexual abuse. These risk factors include:

1. Risk factors associated with direct perinatal transmission of HIV infection from the mother during pregnancy, at birth, or through breast-feeding:

- a. the child had a positive drug toxicology or drug withdrawal at birth;
- b. the child had a positive test for syphilis at birth;
- c. the child has symptoms consistent with HIV infection;
- d. a sibling 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;
- e. the child was abandoned at birth and no risk history is available.

2. Risk factors related to the medical and psychosocial history of the child's mother or father, or a sexual partner of the child's mother or father, generally relevant only to an infant or young child through perinatal transmission:

- a. the individual has a diagnosis of HIV infection, or symptoms consistent with HIV infection, or death due to HIV-related illness or AIDS;
- b. the individual has or had a male sexual partner who has had sex with another man;
- c. the individual has a history of sexually transmitted diseases, such as syphilis, gonorrhea, hepatitis B, or genital herpes;
- d. 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. the individual has a history of tuberculosis;
- f. the individual is known or reported to inject illegal drugs or share needles, syringes, or other equipment

- involved in drug use or body piercing;
- g. the individual is known to use non-injection illegal drugs, such as crack cocaine;
- h. the individual had a transfusion of blood or blood products between January 1978 and July 1985 in the United States of America; or
- i. 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.

3. Risk factors related to children and adolescents and associated with the child's behavior or with direct transmission from another person after the child's birth:

- a. the child has symptoms consistent with HIV infection;
- b. the child has been sexually abused;
- c. the child has engaged in sexual activity;
- d. the child has a history of sexually transmitted diseases, such as syphilis, gonorrhea, hepatitis B, or genital herpes;
- e. the 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. the child has a history of tuberculosis
- g. the child is known or reported to inject illegal drugs or share needles, syringes or other equipment involved in drug use or body piercing;
- h. the child is known or reported to use non-injection illegal drugs, such as crack cocaine;
- i. the child had a transfusion of blood or blood products between January 1978 and July 1985 in the United States of America; or
- j. the child had a transfusion of blood or blood products in any other country at a time when the blood supply was not screened for HIV infection.

E. OBTAINING LEGAL CONSENT FOR HIV TESTING WHEN RISK IS IDENTIFIED

If the required HIV risk assessment for a child in foster care identifies one or more risk factors for the child, the authorized agency must obtain legal consent from an appropriate individual before the child's HIV test can take place.

1. When a child lacks capacity to consent and is placed in foster care under Article 10 of the Family Court Act as an abused or neglected child, 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 SSL or section 1022, 1024, or 1027 of the FCA, and HIV risk is identified, designated staff must:

- a. make a reasonable effort to inform the parent or guardian of the child of a positive HIV risk assessment and recommendation for testing;

b. request that the parent or guardian provide written permission within 10 business days for the testing of the child (see Appendix D for model form);

c. if permission signed and dated by the parent is received within the required timeframe, make an effort to discuss with the parent the parent's ability and willingness to accompany the child to the test site;

OR

explain to the parent that the agency will take responsibility for making arrangements for the testing, accompanying the child to the testing site, and providing the official consent signed by the commissioner or designated representative, keeping the parent informed of the procedures and results;

d. if there will be parental participation in the testing process, assist by arranging an appointment, providing transportation as needed, and informing the parent that staff at the testing site will provide pre- and post-test counseling and require the parent's signature on the official Department of Health informed consent form;

e. if the child's parent does not respond within the required timeframe, refuses to consent to the testing, or is unwilling or unable to participate in the testing procedures for the child, make arrangements for the HIV testing of the child and obtain the required written informed consent form (see Appendix C for the official form) signed by the commissioner or designated representative who must provide legal consent in such circumstances for the child's HIV test;

f. retain in the medical record section of the uniform case record a copy of the official Department of Health written consent form signed by the commissioner or designated representative and provided to the testing site.

2. When a child lacks capacity to consent, is placed in foster care as a result of parental surrender or termination of parental rights by the court, and HIV risk is identified, designated staff must:

a. make arrangements for the child to be tested;

b. obtain legal consent from the commissioner or designated representative who must provide the necessary signed official written informed consent on the Department of Health form (Appendix C);

c. retain a copy of the signed consent form provided to the testing site in the medical record section of the uniform case record.

3. When a child lacks capacity to consent, is placed in foster care voluntarily by his or her parents or by the court as a Person in Need of Supervision (PINS) or a Juvenile Delinquent (JD), and HIV risk is identified, designated staff must:

a. immediately inform the parent or guardian of the results of the assessment, and recommend testing;

b. explain testing procedures to the parent or guardian;

c. request written permission from the parent or guardian within 10 business days to make arrangements for HIV testing of the child (see model form in Appendix D);

d. if written permission is received, make arrangements for the test and for the parent or guardian to accompany the child to sign the official Department of Health written informed consent form at the test site;

e. if permission is denied by the parent or guardian, offer the parent/guardian the opportunity to meet with agency staff to discuss the assessment of risk factors and the importance of testing in order to provide medical care and services for any child who is HIV-infected;

f. if the parent/guardian continues to refuse permission, document that fact in the case record. Without parental consent, HIV testing of the child in this category cannot take place unless the agency secures a court order based on urgent medical necessity (as defined on pages 16-17 of this directive).

g. if the parent/guardian cannot be located, is incapacitated or deceased, seek a court order to allow for HIV testing.

4. When a foster child has been determined by the authorized agency to have the capacity to consent, and HIV risk has been identified, the child or youth has the right to make all decisions regarding an HIV test, the type of test, and a limited right to make certain decisions regarding disclosure of information related to an HIV test. Designated staff must respect these rights and must never use threats or coercion in an effort to persuade the child or youth to consent to testing.

In following required procedures to obtain consent from the child, the designated staff must:

a. inform the child of the results of the assessment of risk factors for HIV infection, including the specific risk factor(s) identified as the basis for the recommendation for HIV testing, 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, as described in Section 441.22(b) (8) of Department regulations;

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;

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

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

if the child indicates that he or she will not agree to be referred for either form of testing, continue as part of the ongoing casework contacts with the child to discuss the importance of HIV related testing.

f. 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.

g. The child's decision pertaining to consenting or not consenting to HIV-related testing must be documented in the child's case record, and a copy of any signed written

agreement to be tested (see model form in Appendix E) also must be retained in the case record

h. Ensure that the child understands that, at any future time, the issues of HIV risk and testing may be reopened and discussed either at the request of the child or by agency staff.

++++  
Authorized agencies must inform certified foster parents, approved relative foster parents, and prospective adoptive parents that they do not ever have legal authority to provide written consent at a testing site for HIV testing of children placed in their care.  
++++

F. HIV TESTING OF CHILDREN IN FOSTER CARE

1. If a child in foster care is determined to have one or more of the risk factors listed in section IV. D of this directive, authorized agency staff must make arrangements for HIV testing to take place provided the required legal consent has been obtained:

a. within 30 business days of the child's entry into foster care if the initial assessment of the child indicated no possibility of capacity to consent (Please note that this timeframe is intended to correspond to the requirement for the child's initial comprehensive physical examination within 30 days of entry into care in accordance with section 421.22 of Department regulations and 90 ADM-21.);

b. within 60 business days of the child's entry into foster care if the initial assessment of the child indicated that there was a possibility that the child may have a capacity to consent, and the follow-up assessment completed within 30 days of entry resulted in a decision that the child did not have capacity to consent;

c. within 60 business days of the child's entry into foster care if the child was determined to have the capacity to consent and agreed to provide written consent to testing.

2. When a medical provider for the child in foster care recommends the HIV testing of the child based on medical/social history or symptoms, the authorized agency must begin immediately to initiate the procedures necessary to obtain legal consent before such testing can take place, unless the physician determines there is a medical emergency, in which case the physician may require the test be performed without consent. The child with capacity to consent retains the right in such situations to make his or her own decision regarding testing.

3. The HIV testing of a child or youth in foster care must be conducted:

a. under the direction of licensed medical personnel, who may be medical staff employed by the authorized agency or in designated testing centers or clinics;

b. at a designated testing center, medical facility or office.

4. Each service plan review and each periodic medical examination of a child that occurs after the initial assessment of the child pursuant to Section 441.22(b)(2) of Department regulations must include an assessment by designated agency staff of whether HIV-related testing 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. If it is determined that HIV testing is recommended, the authorized agency must initiate the process to obtain legal consent. If the written informed consent for the HIV-related testing of the child is obtained, the agency must arrange for testing within 30 business days of the recommendation.

G. SERVICES REQUIRED FOLLOWING HIV TESTING OF A CHILD IN FOSTER CARE

If a child in foster care tests positive for HIV infection, the authorized agency must:

1. provide or arrange for counseling of the child as needed and age appropriate in addition to any post-test counseling at the test site (see pages 17-20 for a discussion of practice issues involved in providing or arranging counseling for the child, for foster parents, prospective adoptive parents, or the parent/guardian of the child);

2. arrange for all follow-up medical services needed by the child as a result of the HIV test, including any additional tests recommended by the child's medical provider;

3. provide support services and counseling as needed to the child's parents and foster parents caring for a child who tests positive for HIV infection.

H. DOCUMENTATION RELATED TO THE ASSESSMENTS AND HIV TESTING OF A CHILD IN FOSTER CARE

Authorized agencies must document specific information related to the assessments and HIV testing of a foster child in the uniform case record. The authorized agency must document the following information in the medical record section of the uniform case record:

1. decision on the assessment of the child's capacity to consent, reason for the decision, and the date of the decision;

2. confirmation that the assessment of HIV risk factors was conducted within required timeframes;

3. identification of any risk factors listed on pages 23 and 24 of this directive;
4. information on any follow-up assessments;
5. a copy of the written consent for HIV testing provided by the parent or guardian of the child, the child with capacity to consent, or the commissioner or designated representative, as applicable;
6. documentation of the parent's or child's refusal to provide consent, as applicable;
7. date and location of any HIV testing of the child;
8. type of HIV test:
  - a. confidential or anonymous (anonymous is a choice available in foster care only to the child/youth with capacity to consent);
  - b. antibody (elisa, western blot) or viral (polymerase chain reaction (PCR));
9. results of the HIV test and any recommendations by the medical provider for follow-up tests or medical treatment for the child;
10. information and counseling sessions provided to an HIV-infected child;
11. information and counseling sessions provided to the parent of an HIV-infected child without capacity to consent who has a permanency planning goal of return home;
12. information and counseling sessions provided to the parent of an HIV-infected child with capacity to consent only if the child/youth has provided written consent to provide such HIV-related information concerning himself or herself to the parent;
13. information and counseling sessions provided to the foster parents or prospective adoptive parents caring for an HIV-infected child;
14. specific plans for training and support services for foster parents or prospective adoptive parents caring for an HIV-infected child.

I. CONFIDENTIALITY AND DISCLOSURE OF HIV-RELATED INFORMATION CONCERNING THE FOSTER CHILD

All person-specific HIV-related information must be maintained in a confidential manner, as required by Section 431.7 of Department regulations. In all cases when HIV-related information is made available as described in this section, a warning statement against further disclosure or redisclosure must be provided to those

receiving such information except those persons listed in paragraph 4 of this section. (For a copy of the warning statement, see Appendix A.)

1. Authorized agencies must insure that direct access to HIV-related information concerning a foster child is limited to:
  - a. an authorized agency responsible for the foster care or adoption of such child;
  - b. staff within that authorized agency who need to know such information in order to supervise, administer, monitor, or provide services for the specific HIV-infected child or child's family;
  - c. the child's medical care provider or medical facility;
  - d. the child with capacity to consent;
  - e. a person authorized by law to consent to health care for a foster child who lacks capacity to consent.
  
2. Authorized agencies must disclose HIV-related information concerning a specific foster child, whether or not the child has capacity to consent, to the following:
  - a. certified foster parents and approved relative foster parents caring for the HIV-infected child;
  - b. prospective adoptive parents and adoptive parents of the child freed for adoption;
  - c. another authorized agency when the child is transferred to that agency or agency facility for placement or treatment;
  - d. the law guardian of the child;
  - e. a foster child discharged to his or her own care; and
  - f. an adopted former foster child upon request.
  
3. Authorized agencies must disclose HIV-related information concerning a specific foster child to the following only under certain conditions:
  - a. the parent or guardian of the foster child if the foster child lacks capacity to consent;
  - b. the parent or guardian of the foster child with capacity to consent only if the child provides written consent to disclosure of the information to the parent or guardian;
  - c. in a court hearing related to the foster child only when directly ordered by a judge after a hearing on the issue of

disclosure (such information must not be provided in response to a subpoena, in accordance with Public Health Law, Article 27-F);

d. external services providers only when necessary to obtain essential health or social services for the foster child and only when the commissioner or designee has signed specific authorization for the release of such information, including the reason for the release, the warning statement against any redisclosure, the signature and date of signature from the person receiving such information. Examples: psychologist, home aide, day care or school staff (day care or school staff only when medication or other medical necessity directly related to HIV infection or AIDS is involved). (See model form in Appendix B.)

4. The right of a person in #2 or #3 to redisclose confidential HIV-related information concerning a foster child is limited to the following persons:

a. a prospective adoptive parent of a foster child freed for adoption, or an adoptive parent, without condition;

b. a certified foster parent or approved relative foster parent caring for the child, only when necessary for the care, treatment or supervision of the child;

c. the law guardian of the child when necessary to represent the child without capacity to consent in court proceedings;

d. the law guardian of the child when necessary to represent the child with capacity to consent in court proceedings only if the child with capacity to consent has provided written consent for such disclosure.

J. RECRUITMENT OF FAMILIES TO CARE FOR HIV-INFECTED CHILDREN IN FOSTER CARE

Authorized agencies operating foster boarding home and/or adoption home programs must include in their community relations efforts information regarding the need for foster and prospective adoptive families who may be able and willing to provide care for HIV-infected children identified by these HIV assessment and testing requirements.

V. REPORTING AND SYSTEMS IMPLICATIONS

Each authorized agency is required to document the HIV risk assessment and testing, as appropriate, for each child in foster care in accordance with Department regulations and this directive.

VI. ADDITIONAL INFORMATION

Additional information is provided through Appendices attached to this directive.

Date July 24, 1997

Trans. No. 97 ADM-15

Page No. 33

VII. EFFECTIVE DATE

The effective date of this Administrative Directive is August 15, 1997, retroactive to August 23, 1995 which was the effective date of Department regulations requiring authorized agencies to implement the HIV assessment and testing program for New York State children in foster care.

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Rose M. Pandozy  
Deputy Commissioner  
Division of Services and  
Community Development

APPENDIX A

WARNING NOTICE

AGAINST REDISCLOSURE

OF CONFIDENTIAL HIV-RELATED

INFORMATION

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

(See other side for Spanish translation.)

NOTIFICACION DE ADVERTENCIA  
CONTRA LA REVELACION DE INFORMACION CONFIDENCIAL  
RELACIONADA AL HIV

La información que se le ha revelado proviene de récords confidenciales que están protegidos por la ley del Estado. La ley del Estado le prohíbe a usted proveer más revelaciones con respecto a esta información sin la aprobación específica de la persona a quien se refiere o sin el permiso de la ley. Cualquier revelación adicional que no esté autorizada constituye una violación de la ley del Estado y puede que resulte en una multa o una sentencia de cárcel o ambas. Una autorización general para proveer información médica u otro tipo de datos no constituye una autorización suficiente para hacer más revelaciones.

APPENDIX B

Authorization for Redisclosure of Confidential HIV-Related Information
[Please Note: This completed form must be returned to the agency responsible for the care of the child.]

I hereby authorize redisclosure of confidential HIV-related information by (name of agency) concerning (child's name) to (person or agency) for the following time period (check one):
specific dates:
while child remains in care of above-named person(s)
until services are completed

The purpose for authorizing redisclosure as permitted by Article 27-F of the Public Health Law and Department regulations:

I am legally permitted to authorize redisclosure because I am:
the child named above
the birth parent or legal guardian of the child (where the child lacks capacity to consent)
the social services commissioner
the designated representative of the commissioner (indicate title with signature)

Signature
Title (if appropriate)

Warning Statement on Redisclosure Except to Authorized Persons
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.

Receipt of Confidential HIV-related Information
I have received confidential HIV-related information and have read the warning statement required by law. I understand the penalties for further redisclosure without written permission.

Signature Date
(person receiving confidential information in order to provide services)

APPENDIX C  
REQUEST FOR PARENTAL PERMISSION TO TEST CHILD FOR HIV INFECTION  
(For a child without capacity to consent)

I have been informed that my child, \_\_\_\_\_, has been found by the agency where he/she has been placed in foster care, to be at risk for HIV infection. The agency recommends testing to determine whether the child is infected so that care and treatment can be given as necessary.

I understand that the agency is requesting my permission for the child to be tested, and that this form must be returned to the agency within 10 business days.

I understand that if I give my permission for my child to be tested, the agency will make arrangements for the test.

If the agency asks me to go to the HIV test site with my child and I agree to go, I understand that I would be asked to sign the Department of Health consent form and receive pre-test counseling at the test site.

I would need transportation to the testing site in order to take my child.

Yes\_\_\_ No\_\_\_

If my child was placed in foster care by the court for abuse or neglect, I understand that the agency may give consent and arrange for my child to be tested for HIV even if I do not sign and return this permission slip or if I refuse to give my permission for the test.

If my child was placed in foster care for reasons other than protective removal or placement (abuse or neglect), I understand that the agency may not give consent and arrange for my child to be tested for HIV. My child will not be tested unless I give permission or a court order is obtained. If I give permission, I understand that I must go with my child to the testing site.

I give my permission for my child placed in foster care to be tested for HIV infection.

Yes\_\_\_ No\_\_\_

I understand that the agency will inform me regarding the results of the HIV test.

Signed by \_\_\_\_\_ (parent)

Date \_\_\_\_\_

Received by agency staff \_\_\_\_\_ (signature)

Date \_\_\_\_\_

APPENDIX D

DECISION REGARDING TEST FOR HIV INFECTION BY CHILD WITH CAPACITY TO CONSENT

I have been informed by agency staff that they believe I am at risk for HIV infection. Agency staff have explained the reason(s) why they believe I am at risk for HIV infection. I understand the importance of being tested in order to receive any necessary treatment and services.

I understand that if I agree to be tested, I will receive pre-test counseling at the testing site and will be asked to sign the official Department of Health written informed consent form.

I understand that if I agree to be tested, I may choose between confidential (agency-supervised) testing or anonymous testing (where I would be identified only by number).

I understand that I will be given the results of the test, whether confidential or anonymous. If I choose anonymous testing, no other person or agency will be given the results of the test. If I choose confidential testing, the agency will also receive the results of the confidential test, as will other persons required by law to be given the results. In either case, my parents could not be given the results without my written permission.

I understand that the agency will make arrangements for the test and for any necessary transportation to the test site.

I agree to be tested for HIV infection.

Yes \_\_\_\_\_ No \_\_\_\_\_

If I have checked "Yes," I choose:

Confidential testing \_\_\_\_\_  
Anonymous testing \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

Agency staff \_\_\_\_\_

Date \_\_\_\_\_

APPENDIX H

NEW YORK STATE INDEPENDENT LIVING TRAINING NETWORK  
WITH INFORMATION AND RESOURCES AVAILABLE ON ADOLESCENT ISSUES

Region 1:

Buffalo State College  
Center for Development of  
Human Services  
Campus West  
1300 Elmwood  
Buffalo, NY 14222

(716) 882-1117

Region 2:

Buffalo State College  
Center for Development of  
Human Services  
1210 Jefferson Road  
Rochester, NY 14623

(716) 292-5010

Regions 3 and 4:

State University of New York  
at Albany  
Professional Development Program  
135 Western Avenue  
Albany, NY 12222

(518) 442-5700

Region 5:

State University of New York  
at Stony Brook  
School of Social Welfare  
Stony Brook, NY 11794-8231

(516) 444-7565

Region 6:

South Bronx Human Development  
Center  
One Fordham Plaza, Suite 900  
Bronx, NY 10458

(718) 295-5501

+-----+  
 | ADMINISTRATIVE DIRECTIVE |  
 +-----+

TRANSMITTAL: 91 ADM-36

TO: Commissioners of  
 Social Services  
 Directors of Voluntary Child  
 Caring Agencies

DIVISION: Family &  
 Children  
 Services

DATE: September 16, 1991

SUBJECT: Foster Care and Adoption: HIV-Related Issues and  
 Responsibilities

SUGGESTED

DISTRIBUTION: Directors of Services  
 Services Staff  
 Staff Development Coordinators  
 Legal Staff

CONTACT

PERSON: Your Regional Office Director

Albany: John O'Connor, (518) 432-2751  
 Buffalo: Linda Brown, (716) 847-3145  
 Metropolitan: Fred Cantlo, (212) 804-1202  
 Rochester: Linda Kurtz, (716) 238-8200  
 Syracuse: Jack Klump, (315) 428-3235

ATTACHMENTS:

Appendix A: References to Title 18 Regulations  
 Affected by HIV Confidentiality (available on-line)  
 Appendix B: Authorization for Rediscovery  
 (Model Form) (available on-line)  
 Appendix C: Warning Statement in English and  
 Spanish (available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serve Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
85 INF-14 90 ADM-21	85 INF 14	(See list in Appendix A)	SSL 372 373-a 383-b PHL Article 27-F		

DSS-296EL (REV. 9/89)

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I. PURPOSE

The purpose of this directive is to inform you of the requirements of Chapter 584 of the Laws of 1988 and Chapter 592 of the Laws of 1990 concerning confidentiality of AIDS and HIV-related information affecting foster and adoptive children and families. This directive also discusses implementation of Department regulations mandated by Chapter 584.

The directive requires non-discrimination in eligibility determination and provision of services for children and families affected by AIDS or HIV infection; adoption of local procedures to safeguard confidential information related to HIV infection (including AIDS or HIV-related illnesses); and procedures for access to and redisclosure of confidential HIV-related information when authorized by Chapter 584 and by Chapter 592.

II. BACKGROUND

In response to issues resulting from the human immunodeficiency virus (HIV) epidemic, the New York State Legislature enacted Chapter 584, including a new Article 27-F of Public Health Law (PHL), which addressed the issues of disclosure of confidential HIV-related information and administration of HIV-related tests. Chapter 584 also amended Section 373-a of Social Services Law (SSL) to authorize disclosure of confidential HIV-related information to foster parents, prospective adoptive parents and adoptive parents. Chapter 584 became effective on February 1, 1989.

The legislative intent was to assure that confidential HIV-related information is not improperly disclosed and that clear standards exist for disclosing such information. State agencies which receive confidential HIV-related information were required to promulgate regulations to implement the new law. While Chapter 584 applies to HIV-tested and HIV-infected persons of all ages and circumstances, State Department of Social Services regulations were amended to include those individuals and families in need of expanded human services because of HIV infection. These regulations became effective on September 12, 1989.

PLEASE NOTE: According to law, "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..."

By assuring protection of the confidentiality of HIV-related information, the Legislature hoped to encourage voluntary testing for the virus by persons at risk "so that individuals may come forward, learn their health status, make decisions regarding the appropriate treatment," and change at-risk behavior. There was also intent to limit the risk of discrimination which might be caused by unauthorized disclosure of confidential HIV-related information.

Following implementation of Chapter 584 through regulatory amendments, social services agencies and foster parents raised numerous questions regarding the difficult relationship between the law's confidentiality requirements and the foster family's ability to care for and access services for HIV-infected foster children. As a result, the Legislature enacted Chapter 592 of the Laws of 1990, exempting foster parents from the confidentiality provisions of Article 27-F of Public Health Law when disclosure of confidential HIV-related information is necessary "for the purpose of providing care, treatment or supervision" of the foster child. Chapter 592 also exempts from such confidentiality restrictions prospective adoptive parents with whom a child has been placed for adoption. The same law adds the law guardian to the list of those who are authorized to have access to confidential HIV-related information concerning a foster child under specific circumstances.

The number of HIV-infected children in New York State has continued to rise. While the highest percentage of cases is concentrated in New York City, all regions of the State are currently affected. All agencies need to be prepared through staff training and planning to meet the needs of families and children affected by HIV infection and to meet the requirements of the law and regulations. This directive addresses the particular confidentiality issues affecting foster and adoptive children with HIV infection.

### III. PROGRAM IMPLICATIONS

#### A. Access to Confidential HIV-Related Information

Authorized agencies should be aware that access to confidential HIV-related information in the case files of foster or adoptive children must be given to specific persons or agencies. Access is also authorized to governmental agencies, and health or social services providers when it is reasonably necessary for the supervision, monitoring, administration, or provision of services to the child or child's family. The development and oversight of safeguards to the access of confidential HIV-related information in case files are responsibilities of the local district social services commissioner and directors of voluntary agencies.

1. Social Services Law 373-a and Section 357.3(b) of Department regulations require that a child's comprehensive medical history, including HIV-related information, must be provided to the following:
  - a. another authorized agency to whom the care of a foster child is transferred;
  - b. certified foster parents or approved relative foster parents;
  - c. prospective adoptive parents\* and adoptive parents;
  - d. the child's parents or guardian when the child is released to their care;
  - e. the child discharged to his or her own care;
  - f. any adopted former foster child, upon request, as required by Chapter 165 of the Laws of 1990.

Prior to placing an HIV-infected child with either foster or prospective adoptive parents, the caseworker should determine whether the parent is willing to care for an HIV-infected child, since children infected with this disease may require substantially more support and care than other children. If the response is positive, then the caseworker will need to make a further assessment of the emotional stability, attitudes and physical ability of the parents to provide the exceptional level of care such children may need. Preliminary discussions concerning placement of an HIV-infected child should be general and should not provide confidential HIV-related information about a child until a specific placement plan is being considered.

EXCEPTION: In the case of placement in an approved relative foster home, which often occurs as an emergency situation, obviously a specific child or children will be involved. In such cases it is essential to inform the relative of the child's condition, if known, and assess prior to placement the relative's willingness and capacity to care for or adopt the HIV-infected child.

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\*"Prospective adoptive parents" are persons who have met criteria and standards for adoption through screening and home study as specified in Section 421.16 of Department regulations, who have indicated an interest in adopting a particular child, and for whom the authorized agency has begun the placement agreement process described in Section 421.18 of Department regulations.

Certified foster families who are willing to accept responsibility for the care of such children should be informed before the actual time of placement if a child to be placed in their care is known to be an HIV-infected child. Except in extreme emergency situations, persons accepting such children should be offered advance preparation and counseling prior to placement. In any case, Department regulations require that such information must be given to the foster parent at the time of the child's placement.

Again, confidential information on the HIV status of a particular child may not be given to applicants for adoption until the authorized agency has begun the specific placement agreement process described in Section 421.18 of Department regulations. However, caseworkers should determine whether the applicants are willing to accept an HIV-infected child. The general questions of willingness and capacity to care for such a child should always be resolved prior to actual placement. Child-specific HIV-related and other health information may appropriately be given, for example, when visitation prior to placement is being arranged between the prospective adoptive parents and the adoptable HIV-infected child. At that time agency staff should discuss with the prospective adoptive parents the HIV status of the child.

2. The law and Department regulations clearly permit access to confidential HIV-related information in case records when there is a "need to know" in the ordinary course of business and provision of services. Specifically, an authorized employee or agent\* of an authorized agency may have access to such information when it is reasonably necessary for the supervision, monitoring, administration, or provision of services to the child or child's family. The same standard is applicable to facilities operated by authorized agencies, including agency boarding homes, group homes, group residences and institutions. The medical history, including any confidential HIV-related information, of each child placed in foster care in such facilities, should be accessible to the caseworker, supervisor, health personnel, treatment team or other persons needing such information in order to supervise, monitor, administer or provide services to the child.

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\*The law defines "authorized employee or agent" as "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."

Local agency officials will determine which staff persons "need" to have access to this information. Practical, common sense judgment will dictate these decisions. For example, the caseworker assigned to a specific case, as well as the caseworker's supervisor, will need access to the case file which includes records of all medical tests and diagnoses. A support staff person assigned to enter case information into computerized records has a "need to know." The third party reviewer of a case record involving confidential HIV-related information has a "need to know."

In all circumstances when access to confidential HIV-related information is necessary, the authorized agency's administration is responsible for providing to those persons receiving the information the written statement (Appendix C) warning of penalties for unauthorized redisclosure.

The law guardian of the child, appointed to represent the child in legal proceedings, has a "need to know" confidential HIV-related information as authorized by Chapter 592 of the Laws of 1990. However, the law guardian's authority to redisclose such information is limited (see C.1.b. on p. 12).

B. Safeguards to Access

1. In order to ensure that confidential HIV-related information is accessible only to authorized employees and that policies are in place to safeguard access, each authorized agency is responsible for developing a written management plan which will be available for review upon the request of the Department. (See Section 431.7(a)(1) of Department regulations.) Since all child welfare case files are confidential, it is assumed that basic procedures for protection of information are already in place. Such procedures should be reviewed to ensure that access to files is limited to authorized persons and that files are secured. Confidential HIV-related information which is stored electronically must also be protected from access except by authorized individuals.
2. It is essential that authorized agencies provide information and training for all staff in the requirement for confidentiality of HIV-related information and in the legal penalties for unauthorized access and redisclosure. The law requires that the following written warning statement must be provided to all persons with current or past access to such information:

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

(See Appendix C for warning statement in English and Spanish for reproduction and distribution.)

Unauthorized disclosure of confidential HIV-related information, whether through deliberate action or negligence, will result in the person disclosing such information to be subject to civil penalties not to exceed \$5,000 for each occurrence. A person willfully disclosing such information without authorization may also be found guilty of a misdemeanor, according to Article 27-F of the Public Health Law.

C. Redisclosure of Confidential HIV-related Information

Redisclosure of confidential HIV-related information concerning a foster or adoptive child by persons or entities with authorized access to such information is permitted under certain circumstances and when required procedures are followed.

1. Persons who may redisclose without prior written authorization or consent:

a. the local social services commissioner and his/her designated representative when the child lacks capacity to consent and:

- (1) the social services district has taken protective custody of the child; or
- (2) the child has been adjudicated as an abused or neglected child and custody has been transferred to the social services district; or
- (3) the guardianship of the child has been transferred to the social services district after parental surrender or termination of parental rights.

- b. the law guardian of the child "for the sole purpose of representing the minor" child if that child lacks capacity to consent. (See III.C.3 on p. 13 for definition and discussion of capacity to consent.) If a determination has been made that the child has capacity to consent, the law guardian may not redisclose confidential HIV-related information without the child's written consent.
- c. the prospective adoptive parent with whom an HIV-infected child has been placed for adoption.
- d. the foster parent caring for an HIV-infected child when redisclosure is necessary for the purpose of providing care, treatment, or supervision of the foster child.

Persons to whom foster parents redisclose confidential HIV-related information should be provided the warning statement (Appendix C) against further redisclosure.

- 2. The following guidelines indicate acceptable reasons for foster parents to redisclose to otherwise unauthorized persons confidential HIV-related information concerning the foster child in their care:
  - a. to persons living in the household with the child and providing care and/or emotional support for the child;
  - b. to relatives, neighbors or others directly and substantially involved in the care or supervision of the child;
  - c. to other members of a support group for foster parents caring for HIV-infected children. The formation of such support groups of foster parents with a common experience in caring for HIV-infected children is highly desirable and is to be encouraged. Such groups can be essential in sharing information related to the disease and to the care of such children and in providing strong emotional support which will assist in the care, treatment and supervision of the child.
  - d. to in-home services providers when necessary for the medical care of the child or to obtain specialized services. These may include home health aides, homemakers, respite care providers, in-home day care providers, or in-home educational personnel.
  - e. to day care providers and schools only when medical necessity, such as giving a medication prescribed by a physician, requires redisclosure.

PLEASE NOTE: Out-of-home day care providers and schools are not permitted to require confidential HIV-related information as a condition for admission.

Caseworkers are advised to counsel with foster parents of older pre-adolescent or adolescent foster children regarding their planned redisclosure of confidential HIV-related information concerning such children. Foster parents, while given the right to redisclose for the purposes specified above, should be sensitive to children's feelings about redisclosure and should consider how the children and the informed persons are likely to respond. Caseworkers and/or foster parents may find a discussion of this issue with older children appropriate and beneficial.

PLEASE NOTE: A child with capacity to consent\* (for example, an adolescent) cannot prohibit access or redisclosure to persons or entities expressly authorized by law to receive confidential HIV-related information (for example, foster parents and authorized agencies).

3. Except as discussed above in Section C.1 and 2, redisclosure of confidential HIV-related information to previously unauthorized persons is not legally permitted without specific written authorization by the person or entity legally authorized to consent to medical care for the child or by the child with capacity to consent.

Persons who may provide written authorization/consent for redisclosure:

- a. The foster/adoptive child himself or herself with "capacity to consent."

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\* According to law, "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.

The question of capacity to consent to redisclosure requires a determination by the local social services commissioner or designated representative in consultation with other professional staff who may include a physician, psychologist, or caseworker, as well as the foster or adoptive parents. A decision should take into consideration the maturity of the child and the child's ability to fully comprehend and appreciate the consequences and implications of the redisclosure of such information. Even for older children who may be deemed fully able to understand, counseling and interpretation are essential prior to the child's signing an authorization for redisclosure.

b. The birth parent of a child placed voluntarily into foster care.

A signed authorization for redisclosure of confidential HIV-related information concerning the child may be requested from the parent at the time a child is voluntarily placed in care. In the absence of written parental consent where applicable, and when a child lacks capacity to consent, court authorization or conversion of the case to protective custody under Article 10 may be necessary to allow redisclosure to persons or entities not expressly granted access.

c. The social services commissioner or designated representative.

When a local social services commissioner has taken a child into protective custody or has been awarded custody or guardianship of the child by the court, the local commissioner or designated representative may authorize redisclosure to specific, named persons, stating the reason for such redisclosure. Again, this written authorization to redisclose is not required for adoptive parents, for law guardians representing minors, or for foster parents when redisclosure is necessary for the care, treatment and supervision of foster children.

4. When written authorization to redisclose confidential HIV-related information to a specific person is necessary, the local social services commissioner or designated representative is also responsible for providing to the person to whom the information is given the warning statement required by law. A model form for this purpose, "Authorization for Redisclosure of Confidential HIV-related Information," is attached in Appendix B. Please note that this form includes both the authorization and the warning statement and is to be signed by both the person authorizing redisclosure and the person receiving the confidential information.

D. Medical Records

1. In safeguarding medical records within the uniform case record, the authorized agency is obligated to review its continuing practices of maintaining confidentiality of all records. In addition to physical security and protection of files, the agency is responsible for ensuring that only authorized employees (see IV.B. for definition and standard) have access to such records. It is not recommended that the uniform case records of HIV-infected children be set apart in any way from those of other children. Generally, to flag or separate such cases would be to call attention to them and therefore may actually reduce the security of information.
2. Information appropriate for inclusion in the comprehensive health history of the HIV-infected child within the uniform case record includes, but is not limited to, names and addresses of medical providers; actual medical records of treatment and tests provided by physicians, dentists, pharmacists, laboratories, hospitals, or clinics; summaries of medical treatment, psychological testing or counseling, and caseworker observations provided by appropriate professionals; information on health issues provided by parents, relatives, foster parents, school personnel, other persons known to the child; and the progress notes documenting activities such as dates of appointments, dates of consultation with medical providers, dates of transportation provided or arranged for in connection with medical care.
3. Sharing the information in the comprehensive health history of the child with certain persons is mandated by law and regulation (see III.A.1. or IV.C.1.). There is no mandate, however, to turn over copies of the actual medical records of the child.

Authorized agencies may use limited discretion as to whether it is administratively feasible to copy the entire file to present to those persons entitled to the child's medical history. An acceptable alternative may be an informational conference with foster or prospective adoptive parents in which all information is discussed and presented. However, if foster or adoptive parents request copies of documents in the child's health record, copies of those documents should be provided. In such cases, the requirement to safeguard all confidential HIV-related information should be emphasized.

In emergency situations, the caseworker should offer orally to foster parents or residential directors as much information as is available and then follow up with a conference or copied file within the next 72 hours. It is not recommended that agency caseworkers attempt to write summaries of the medical records.

E. Training of Staff

It is essential that each social services district and all other authorized agencies provide information and training for their staff on the law and regulations related to provision of services and confidentiality issues affecting HIV-infected children and families. All those who are involved in the administration, support services, supervision, and casework in the areas of foster care and adoption will need information on policies and procedures required in the care and protection of confidentiality for HIV-infected foster and adoptive children.

Such information and training may be provided through any combination of formal training, informal discussion, and informative materials, so long as all topics required by Section 431.7(c) of Department regulations are covered. (See IV.E. of this directive.)

Some of the required topics are included in an ongoing AIDS training curriculum provided by agencies contracting with the Department or with the New York State Department of Health. Instruction based on local administrative decisions, such as the agency's management plan for safeguarding confidential HIV-related information, will need to be developed locally by staff development personnel. In reviewing the law and regulations governing confidentiality issues, this directive should be utilized so that all staff are aware of the guidelines under which they must perform their tasks. Clearly, it is not necessary for an agency to develop a totally new and comprehensive training curriculum so long as the required topics are covered through one or more training sessions. New staff must be provided with appropriate informational materials and some form of training (formal or informal) on required confidentiality issues within 45 days of employment.

F. HIV Testing of Foster Children

Among issues affected by confidentiality and consent requirements in law and regulation is the question of testing foster children for HIV infection. In view of other policies which may have been established prior to this directive, authorized agencies should review their current practices and policies on HIV testing for compliance with the following Department policy:

1. Testing a child for HIV infection after a child has been placed in foster care is permitted only when, in the judgment of a physician, there is a need for such diagnostic testing on the basis of the child's age, medical history, environmental background, and current physical/developmental condition;

and

when the necessary written, informed consent has been provided.

PLEASE NOTE: Agencies should be aware that commonly available HIV tests for infants are not considered definitive for HIV infection, and that seroconversion from positive to negative often occurs in the first two years of life.

2. Consent for HIV testing of a foster child may be provided by the following persons:

a. the child with capacity to consent (see pages 13 and 14 for definition and discussion);

or

b. the child's parent or legal guardian in cases of voluntary placement or in cases of placement under Articles 3 and 7 (JD and PINS) of the Family Court Act if the child lacks capacity to consent;

or

c. the local social services or health commissioner, if the child lacks capacity to consent, when the child has been taken into protective custody or has been placed in the care and custody of the local social services commissioner as an abused or neglected child under Article 10 of the Family Court Act (FCA).

EXCEPTION: If a physician determines there is immediate and urgent medical necessity for HIV testing of a child in foster care, and if the child lacks capacity to consent, and if the child's birth parents with legal right to consent cannot be located after reasonable effort, the physician may order such testing.

3. The foster child with capacity to consent to HIV testing or the person with legal authority to give consent (e.g., the parent, guardian, commissioner or designated representative), is to receive pre-test information, according to law (PHL Section 2781). The physician who orders the test must certify that written informed consent has been given following provision of information concerning

the test. Such information must include, at a minimum, an explanation of:

- a. the test itself;
- b. the procedures which will be followed;
- c. the confidentiality protections against disclosure except to persons authorized to receive the information;
- d. the nature of AIDS and HIV-related illness;
- e. the possible problems of discrimination if test results are disclosed to unauthorized persons, and the legal protections against such discrimination;
- f. information about behavior which could lead to HIV-infection.

Especially in the case of adolescents in foster care who have been determined to have capacity to consent, the authorized agency should ensure that the child's caseworker or other staff with required training (see III.E.), as well as the child's physician, have made diligent effort to discuss these issues with the adolescent who is to be tested.

Caseworkers should ensure that counseling the adolescent with capacity to consent includes discussion of the requirement for testing information to be recorded in the child's health history which must be given to foster parents. If an adolescent for whom testing is medically indicated refuses to give consent for testing because of this required redisclosure, the worker should refer the adolescent to an anonymous, confidential testing site where counseling and follow-up services are available. The adolescent should be encouraged to reconsider sharing the information in order to receive services and support as needed.

4. Following HIV testing of the foster child, and at the time of giving the test result to the child with capacity to consent, or to the birth parent or guardian, or other person who gave consent for the test, the medical provider who ordered the test and the child's caseworker are responsible for counseling or referring for post-test counseling as appropriate. Such counseling is to include:

- a. coping with emotional consequences of a positive test result;
- b. possible discrimination problems that disclosure of test results may cause;
- c. behavior to prevent transmission or contraction of HIV infection;

- d. available medical treatment;
  - e. in the case of adolescents, the need to notify any sexual contacts;
  - f. an explanation to the tested person of those to whom the test results must be disclosed by law (see IV.C.) and those who are authorized to have access to the foster child's medical record with HIV tests results included.
5. If a physician determines that testing a foster child for HIV infection is necessary, and required consent has been given, the authorized agency placing the child should ensure that the foster parent is given pre-test information and post-test counseling regarding the test implications and results. Such counseling may be given by trained agency staff in consultation with health care providers or may be provided through referrals to other professional counselors. The topics listed in paragraphs 3 and 4 of this section may be used as guidelines.
  6. Results of HIV testing must be included in the child's comprehensive health history in the uniform case record, with access to that information restricted to those who are authorized by law and regulation to have access.

#### IV. REQUIRED ACTION

In order to comply with Chapter 584 of the Laws of 1988 and Chapter 592 of the Laws of 1990 and related Department regulations, the following actions are required:

##### A. Eligibility for Services

Authorized agencies must ensure that safeguards are in place to prevent discrimination against HIV-infected children or families in determining eligibility for services. Further, the social services district is responsible for ensuring that no adverse action occurs against any foster or adoptive child because of a test for or a diagnosis of HIV infection, AIDS, or an HIV-related illness. This will require periodic reviews of procedures, training of staff, and adequate supervision.

##### B. Safeguarding Confidentiality of Records

1. While the confidentiality of all uniform case records must be safeguarded, the authorized agency must take particular care to ensure that the records containing the comprehensive health history of HIV-infected foster and adoptive children are secured from access by unauthorized persons.

2. Each authorized agency must determine which employees will be specifically authorized to have access to confidential HIV-related information on children and families. According to law and Department regulations, only those employees or agents of the authorized agency who have a "need to know" for administration, supervision, monitoring, or provision of services to HIV-infected children and their families may have access to confidential HIV-related information. The local social services commissioner is ultimately responsible for ensuring that procedures are in place to restrict access, both in the local district offices and within any contractor child caring or services agencies.
3. In order to assure such security of access, each authorized agency must develop a written management plan describing procedures for safeguarding records containing the health histories of HIV-infected children. The plan must be available for review by the Department and must include:
  - a. a list by title and/or function of employees authorized to have access to such records because they "need to know" for supervision, monitoring, administration or provision of services;  

PLEASE NOTE: In addition to caseworkers, supervisors and administrators who have a "need to know" confidential HIV-related information, support staff involved in record keeping, data entry or accounting are examples of those who may be included in the list of employees authorized to have access and who must be provided with the warning statement (Appendix C) against further redisclosure. Third party reviewers also have a "need to know."
  - b. measures which are in place to ensure the protection of electronically-stored confidential HIV-related information from access by persons not authorized under paragraph a. above;
  - c. assurance that the agency is providing information and training on required topics (see IV.E.) for all appropriate staff annually and for new staff within 45 days of employment.
4. All employees with past or current access to confidential HIV-related information must be given the written statement warning against further disclosure of the information without specific authorization.

(See Appendix C for warning statement in English and Spanish for reproduction and distribution.)

C. Mandated Disclosure of Medical History

1. The comprehensive health history of a child, including any confidential HIV-related information, must be given to designated persons according to Section 373-a of Social Services Law and Section 357.3(b) of Department regulations.

Those persons to whom all available health and medical information must be given include the following:

- a. an authorized agency to which a foster child is transferred from another authorized agency;
- b. certified foster parents or approved relative foster parents;
- c. prospective adoptive and adoptive parents (see definition of prospective adoptive parents on p. 8 of this directive);
- d. birth parents or guardian when the foster child is released to their care;
- e. a foster child discharged to his or her own care;
- f. any adopted former foster child, upon request, as required by Chapter 165 of the Laws of 1990.

PLEASE NOTE: When the birth parents of the child placed in foster care retain guardianship of the child, they should be notified of any HIV-related or any other medical information concerning the child, even if those parents have signed over release/consent for health care to the commissioner.

EXCEPTION: The right of the child who has capacity to consent and who objects to confidential HIV-related information being given to the birth parents overrides the right of parents to receive such information. (Public Health Law Article 27-F)

However, the child with capacity to consent may not prohibit confidential HIV-related information from being given to foster and prospective adoptive and adoptive parents as provided by Section 373-a of Social Services Law.

2. Information which must be included in the comprehensive health history is listed in Section 357.3(b)(6) of Department regulations and in 90 ADM-21, "Medical Services for Children in Foster Care." Among the items to be included in the health history, to the extent available, are results of diagnostic tests, including HIV-related tests, medical treatment and medications prescribed for HIV-infected children.
3. The comprehensive health history of the child must be provided to foster parents at the time of placement, to the extent available. In emergency/crisis situations when placement must be made prior to access to the complete records, the comprehensive health history of the child, to the extent known, must be provided to the foster parents within 72 hours. Moreover, in all cases, a known HIV-infected child should be placed only with foster parents who have previously indicated a willingness to care for such a child.

D. Procedures for Redisdisclosure With Authorization

1. A written and signed authorization for release of confidential HIV-related information concerning a foster child must be provided before redisdisclosure by those persons who have such information except in the following cases:
  - a. A written authorization is not necessary if the person or entity receiving the information is also authorized to have access or is mandated by law to be given such information concerning the specific child.
  - b. In addition, the following persons do not need a written authorization to redisdisclose confidential HIV-related information under certain circumstances:
    - (1) A physician may redisdisclose to the person legally authorized to consent to health care for the foster child when medically necessary to provide timely care and treatment for the child.
    - (2) Foster parents may redisdisclose when redisdisclosure is for the purpose of providing care, treatment or supervision of the foster child placed in their care. (See discussion and guidelines on pp. 11-13.)
    - (3) Prospective adoptive parents with whom the HIV-infected child has been placed for adoption may redisdisclose.

(4) A law guardian may redisclose only when such redisclosure is for the purpose of representing a minor child without capacity to consent or when the child with capacity to consent has given written consent for redisclosure.

2. When an authorization for redisclosure (see Appendix B for model form) of confidential HIV-related information is necessary, it must be written, designated for a specific person or persons and signed by one of the following:

a. the child, if he or she has the capacity to consent and fully understands the implications of such an authorization (see definition of "capacity to consent" on p. 13 of this directive);

or

b. the birth parent or legal guardian of the child if the parent or guardian retains parental rights and can be located;

or

c. the local social services commissioner, or designated representative, when the commissioner is responsible for the health care of the child under conditions specified in Section 383-b of Social Services Law; or has been awarded custody and guardianship of the child by the court, or has assumed guardianship of the child through a voluntary surrender.

A designated representative may be a staff person within the social services district or a voluntary agency, but must function at an administrative level.

3. The written authorization for redisclosure must:

a. be dated;

b. specify the time period during which the release is effective;

c. specify the reason for authorizing redisclosure;

d. include the warning statement (Appendix C) against further redisclosure without written authorization.

A model form incorporating these requirements is attached to this directive as Appendix B. Both the person consenting to release of the confidential HIV-related information and the person receiving the information are required to sign the form which must be retained in the uniform case record.

Example: A commissioner or designated administrative representative signs the authorization form to permit release of confidential HIV-related information concerning a foster child by a caseworker to a counselor working with a special needs child. The staff person must then obtain the counselor's signature indicating receipt of the information and awareness of the warning statement. The signed document is placed in the uniform case record.

4. If, because of some urgent and unforeseen situation, redisclosure becomes immediately necessary for the welfare of the child, the local social services commissioner or a designated representative with authority to redisclose may give oral consent, but must follow up with a written and signed authorization as soon as possible, and in no case later than 10 calendar days from the date of the oral authorization.

E. Training of Staff

1. Each local department of social services and other authorized agencies involved in the care of HIV-infected foster and adoptive children must provide information and training to all staff persons having access to any files or records containing confidential HIV-related information.
  - a. Initial information and training (formal or informal) must be provided within 45 days of employment for all new staff given access to confidential HIV-related information.
  - b. Annually, updated information and refresher training on HIV-related issues must be provided for all staff with access to confidential HIV-related information through any combination of formal training, informal discussion and informative materials, so long as all required topics are covered.
2. Staff information and training must include the following:
  - a. a review of State laws and Department regulations on confidentiality of HIV-related information, including the necessity for written authorization for redisclosure to otherwise unauthorized persons and the warning statement on penalties for unauthorized redisclosure;

- b. a review of the list of persons who have authorized access and those to whom the child's health history, including confidential HIV-related information, must be given by law and regulation (see Section 357.3 of Department regulations and IV.C.1. of this directive);
- c. a review of the agency's written management plan for maintaining security of records;
- d. information on factors (principally blood and semen) and the circumstances which may constitute significant risk of contracting or transmitting HIV infection;
- e. current information which concludes that HIV disease is not transmitted by casual contact or in ordinary home and family care of children;
- f. hygienic measures (universal precautions) recommended to protect persons caring for an HIV-infected child and to protect the HIV-infected child from exposure to other infections. These hygienic measures include:
  - (1) standard practices for thorough cleanliness and infection control; and
  - (2) the use of preventive barriers, such as protective gloves, if the caretaker's skin has open wounds or abrasions, or if there may be presence of blood.

F. Reporting Requirement

All social services districts are required to maintain a tracking file of known HIV-infected children in foster care and to report such children to the Department. Because of the complex issues involved in addressing service needs for these children, discrete tracking information is essential in order to develop resources and to ensure effective program planning for their care. In New York City the tracking file is computerized. All other social services districts must report on DSS Form 3851 (Revised) as soon as information is available concerning HIV infection in a particular child. Information is to be reported by CIN number, not by name, and all information is governed by confidentiality requirements already in place.

G. Purchase of Services

- 1. Social services districts purchasing services and/or foster care maintenance from local public or private non-profit or private proprietary agencies for HIV-infected children must ensure that the written contract includes the following, as well as other requirements of Section 405.3 of Department regulations:

- a. specific procedures to safeguard the child's medical history from unauthorized access or disclosure;
  - b. statements assuring that required information and training will be given annually and to newly employed staff within 45 days of employment;
  - c. statements ensuring that staff who "need to know" confidential HIV-related information for the administration, supervision, monitoring, or provision of services will be fully informed of the penalties for unauthorized redisclosure;
  - d. assurance that any disclosure of confidential HIV-related information will be accompanied by the required warning statement (Appendix C).
2. Foster care maintenance purchased from out-of-state agencies for HIV-infected children must comply with the Interstate Compact On the Placement of Children (see Section 374-a of Social Services Law), and social services districts must ensure that written contracts incorporate the requirements in G.l.a. through d. above.

V. SYSTEMS IMPLICATIONS

None.

VI. ADDITIONAL INFORMATION

Definitions:

- A. The term "handicap" includes being diagnosed as having AIDS, testing positive for HIV infection, or being perceived as susceptible to AIDS or HIV infection. Such persons must be protected from discrimination in accordance with all applicable provisions of Department regulations. (18 NYCRR 303.7)
- B. "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 Services. (Section 2780(1) of PHL and 18 NYCRR 360-8.1)
- C. "HIV infection" means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS. (Section 2780(2) of PHL and 18 NYCRR 360-8.1(a)(2))
- D. "HIV-related illness" means any illness that may result from, or may be associated with, HIV infection. (Section 2780(3) of PHL and 18 NYCRR 360-8.1(a)(3))

- E. "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. (Section 2780(4) of PHL and 18 NYCRR 360-8.1(a)(4))
- F. According to law, "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. (Section 2780 (5) of PHL and 18NYCRR 360-8.1 (a)(8))
- G. "Authorized employee or agent" means any employee or agent who, in the ordinary course of business of the provider or government agency, has access to records relating to the care of, treatment of, or provision of a health or social service to the protected individual. (Section 2782(6)(b) of PHL)

VII. EFFECTIVE DATE

The requirements of this release are effective on October 1, 1991, retroactive to February 1, 1989, the effective date of Chapter 584 of the Laws of 1988. This release also incorporates the requirements of Chapter 592 of the Laws of 1990, effective July 18, 1990.

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Joseph Semidei  
Deputy Commissioner  
Division of Family  
and Children Services

APPENDIX A

References to  
Title 18 Regulations Affected by HIV Confidentiality

<u>AMENDED</u>	<u>ADDED</u>
357.1	303.7
357.3(b)(2), (3)	357.2(b)
357.3(b)(6)	357.3(h)
404.1(a)	360-8.1
405.1(a)	403.9
405.3(g)(12) and (13)	404.1(c)(5) & (6)
432.2(e)(3)(xxix) & (xxx)	405.3(g)(14)(15) & (16)
441.22(b)(2)(viii)	421.1(k)
441.22(c)	421.2(d)
441.22(i)(1)(ii) & (iii)	431.7
441.22(n)(1)	432.2(e)(3)(xxxi)
444.5(c)(13) & (14)	441.22(i)(1)(iv)
444.8(c)(13) & (14)	444.5(c)(15)
487.10(d)(3)	444.8(c)(15)
488.10(c)(2)	485.11(g)
489.14(a)(13)	487.10(d)(4)
491.14(f)(2)	488.10(d)(4)
507.2(a)(2)(viii)	489.14(a)(4)
	490.4 and 491.14(f)(3)
	900.3(b)(1)(xxv)
	900.19

Authorization for Redisclosure of Confidential HIV-Related Information

[Please Note: This completed form must be returned to the agency responsible for the care of the child.]

Date \_\_\_\_\_

I. I hereby authorize redisclosure of confidential HIV-related information

by \_\_\_\_\_

(name of agency)

concerning \_\_\_\_\_

(child's name)

to \_\_\_\_\_

(person or agency)

for the following time period (check one):

- a.  specific dates: \_\_\_\_\_
- b.  while child remains in care of above-named person(s)
- c.  until services are completed

II. The purpose for authorizing redisclosure as permitted by Article 27 F of the Public Health Law and Department regulations:

\_\_\_\_\_

III. I am legally permitted to authorize redisclosure because I am:

- a.  the child named above
- b.  the birth parent or legal guardian of the child (where the child lacks capacity to consent)
- c.  the social services commissioner
- d.  the designated representative of the commissioner (indicate title with signature)

Signature \_\_\_\_\_

Title (if appropriate) \_\_\_\_\_

Warning Statement on Redisclosure Except to Authorized Persons

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.

Receipt of Confidential HIV-related Information

I have received confidential HIV-related information and have read the warning statement required by law. I understand the penalties for further redisclosure without written permission.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(person receiving confidential information in order to provide services)

APPENDIX C

WARNING NOTICE

AGAINST REDISCLOSURE

OF CONFIDENTIAL HIV-RELATED

INFORMATION

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

(See other side for Spanish translation.)

NOTIFICACION DE ADVERTENCIA  
CONTRA LA REVELACION DE INFORMACION CONFIDENCIAL  
RELACIONADA AL HIV

La información que se le ha revelado proviene de récords confidenciales que están protegidos por la ley del Estado. La ley del Estado le prohíbe a usted proveer más revelaciones con respecto a esta información sin la aprobación específica de la persona a quien se refiere o sin el permiso de la ley. Cualquier revelación adicional que no esté autorizada constituye una violación de la ley del Estado y puede que resulte en una multa o una sentencia de cárcel o ambas. Una autorización general para proveer información médica u otro tipo de datos no constituye una autorización suficiente para hacer más revelaciones.

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 90 ADM-21

TO: Commissioners of  
 Social Services  
 Directors of Voluntary  
 Child Caring Agencies

DIVISION: Family and  
 Children  
 Services

DATE: July 6, 1990

SUBJECT: Foster Care: Medical Services for Children in Foster Care

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 SUGGESTED

DISTRIBUTION: | Directors of Services  
 | Children's Services Staff  
 | Medical Assistance Staff  
 | Staff Development Coordinators

CONTACT

PERSON: | Program questions - your Regional Office Director:  
 | Albany - John O'Connor, (518) 432-2751; Buffalo -  
 | Linda Brown, (716) 847-3145; Metropolitan - Fred  
 | Cantlo, (212) 804-1202; Rochester - Linda Kurtz,  
 | (716) 238-8200; Syracuse - Jack Klump, (315) 428-  
 | 3235.

| Systems-related questions - Gerald Seeley, Bureau of  
 | Services Information Systems, 1-800-342-3727, ext. 2-  
 | 2937. Medical Assistance/C/THP questions - Barbara  
 | Meg Frankel, 1-800-342-3715, ext. 3-4054.

ATTACHMENTS: | There are no attachments to this release.

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other	Manual Ref.	Misc. Ref.
		18 NYCRR Parts 357	Legal Ref.	C/THP Program	
75 ADM-73	76 ADM-5	428	SSL 365-a	Manual	
81 ADM-10	84 ADM-40	441	SSL 366		
84 ADM-4		442	SSL 373-a	1988	
87 ADM-22		447	SSL 398	Model	
88 ADM-40		448		Foster	
		463	Public	Parents	
		507	Health Law	Manual	
		508	Article 27		
			PL 101-239	Standards of Payment	
				Program	
				Manual	

DSS-296EL (REV. 9/89)

I. PURPOSE

The purpose of this directive is to inform you of the provisions of Department regulations which establish comprehensive standards for medical services for children placed in foster care. The regulations establish uniform requirements, consistent with current recommended medical practice, for the content and frequency of medical examinations. They also require documentation and monitoring of medical services through recording of medical service activities in the progress notes of the uniform case record and the entry of medical examination dates into the Child Care Review Service (CCRS).

II. BACKGROUND

New provisions in law, concern for the health status of all foster children, and a rising number of infants coming into foster care with serious health problems have contributed to the realization that the State Department of Social Services must address significant health services issues for children in foster care through new and amended regulations. As a result, standards for medical services for children were revised and promulgated in regulations which became effective on January 13, 1989.

Authority and mandate for such services is clear in the law. Section 366 of the Social Services Law requires that Medical Assistance be provided to an otherwise eligible child under the age of 21 years receiving care away from his or her own home. Medical Assistance is defined by Section 365-a of the Social Services Law to mean, in part, "payment of part or all of the cost of care, services and supplies which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, or result in illness or infirmity...."

Such care includes early and periodic screening and diagnosis of eligible persons under 21 years of age to determine any physical and mental disabilities and to treat such disabilities and conditions. The Child/Teen Health Plan (C/THP) in New York State meets the federal mandate for an Early Periodic, Screening, Diagnosis and Treatment Program (EPSDT).

Further, Section 398 of the Social Services Law, which pertains in part to children in foster care, requires the commissioner of a local district to "provide for expert mental and physical examinations of any such child whom he has reason to suspect of mental or physical disability or disease and pay for such examination from public funds, if necessary" and to "provide necessary medical or surgical care in a suitable hospital...."

Another aspect of medical services, access to the child's medical history, is addressed in Section 373-a of the Social Services Law. Previously this law required the medical history of the child, to the extent available, to be provided to an adoptive or prospective adoptive parent and to the child discharged to his or her own care. Chapter 584 of the Laws of 1988 amended this law to extend provision of such information to foster parents. This change was effective Feb. 1, 1989.

### III. PROGRAM IMPLICATIONS

#### A. Uniform Standards for Medical Services

Authorized agencies are responsible for providing comprehensive medical services for all foster children, for documenting such services, and for maintaining current records. The amended Department regulations now set standards based on currently recommended medical practice, sound casework practice, and required health services supervision.

Uniform standards for content and frequency of medical examinations follow the recommendations of the American Academy of Pediatrics of the American Medical Association. To assist authorized agencies in implementing the new medical services standards, the regulations:

1. consolidate regulatory references on medical services for foster children in Section 441.22 of Department regulations;
2. clarify and define the roles and responsibilities of local districts, voluntary agencies, foster parents, and medical providers, all of whom are involved in providing medical services for children in foster care;
3. specify responsibility for reporting and monitoring of medical services by authorized agencies;
4. clarify the requirement that Medicaid-eligible foster children be offered C/THP services;
5. provide for follow-up services after discharge from care;
6. list the individuals who must be provided the comprehensive medical history of the child, to the extent it is available.

#### B. Medical Examinations

Standards ensure that all foster children receive the full range of preventive and primary health care services, including diagnosis and treatment of neglected, chronic or acute medical conditions. The agency responsible for the child's care is also responsible for ensuring that the initial and periodic examination schedule is

followed. Emphasis is on the detection and treatment of any physical or emotional difficulties a child has while in foster care.

C. Informing Foster Parents

Effective casework practice has always included informing foster parents about local agency policies and procedures to be followed in providing medical services for children in their care. Now the law and regulations require that foster parents are provided with the comprehensive health history, to the extent known, of the child placed in their care. Sharing such information is not only required by law, but also enables foster parents to better anticipate the needs of the child in their care and encourages greater involvement in the child's health supervision and treatment plan.

Local agencies are encouraged to review their foster parent manual to be certain it provides foster parents with emergency contacts and procedures in accordance with Section 443.3(p) of Department regulations. (See 88-ADM-40, The 1988 Model Foster Parent Manual.)

In addition, foster care staff, working in cooperation with Medical Assistance staff, need to be well-informed about the range of medical services available in their communities, including psychological services, in order to assist foster parents in formulating a health care plan for the child and to provide appropriate referrals. The local social services district, under Medical Assistance regulations, must keep a list of Medicaid-approved medical providers.

D. Monitoring and Maintaining the Foster Child's Health History File

Documenting the medical services provided and maintaining a health history file for each child in foster care are essential tasks to ensure the child's health needs are met. In addition, oversight and monitoring of the child's medical record by caseworkers, Medical Assistance staff, and supervisors will require ensuring that all items listed for a complete examination have been performed, and that recommendations and referrals for follow-up treatment have been carried out.

E. Medical Services at the Time of Discharge and After Discharge

Since foster children may have less access to medical care after discharge to return home or to independent living, provision is made in the regulations for agencies to assist in the continuation of some medical services for the child. These include discussing with the child's parent or guardian, or with the child discharged to independent living, the importance of continuing medical care. Assistance may also be needed by the family or child in understanding the child's comprehensive health history; the Medical Assistance staff and services caseworker should be knowledgeable and available to provide interpretation and explain recommendations for follow-up

care. Helping the child's family or the child discharged to his or her own care to locate a physician or medical clinic from the district's list of Medicaid providers is the responsibility of the authorized agency at the time of the child's discharge from foster care.

Scheduling comprehensive medical examinations for children prior to discharge to independent living is another agency task in providing medical services. A child returning to care after 90 days have passed is to be considered for health and medical purposes in the same category as a new case and is to receive a comprehensive initial medical examination. While not required, serious consideration should be given to scheduling such examinations when children return to care within 90 days after discharge or after absence without consent, depending on the child's previous history and current condition.

If a child with a goal of independent living is absent without consent, and the case is subsequently closed by the social services district, the agency is not responsible for a final medical examination. Documentation of this situation in the child's health history file is important for possible future case reviews and in the event of the child's return to foster care.

IV. REQUIRED ACTION

A. Disclosure of Health History

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

1. to the receiving agency when the care of the child is transferred from one authorized agency to another for placement;
2. to foster parents at the time the child is placed. If a child is placed on an emergency basis, the health history and medical condition must be immediately provided, to the extent known, and more complete information must be provided as soon as possible, but in all cases within 72 hours.
3. to adoptive parents and prospective adoptive parents\*;

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\* "Prospective adoptive parents" are persons who have met criteria and standards for adoption through screening and home study as specified in Section 421.16 of Department Regulations, who have indicated an interest in adopting a particular child, and for whom the authorized agency has begun the placement agreement process described in Section 421.18 of Department regulations.

4. to parents or guardians at the time of discharge of the child from foster care, including all medical treatment during the time in foster care;
5. to the child himself or herself at the time of discharge to independent living;
6. to the child's physician or medical provider in order to facilitate care and treatment for the child.

PLEASE NOTE: Results of HIV testing and presence of HIV-related illness must be included in medical records of children in foster care, and such information must be given to all the above persons. However, redisclosure of this information by those persons to other persons is forbidden by law without signed informed consent or official written authorization. The following warning statement must be given to all persons to whom the confidential HIV information is disclosed:

"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."

In order to facilitate foster care and adoptive placements while ensuring compliance with the law and regulations governing confidentiality of information related to HIV infection and AIDS, persons applying to become foster or adoptive parents should be asked by the agency at the time of application if they wish to consider fostering or adopting a child with HIV disease. If the response is negative, then no child known to be HIV-infected should be considered for placement in those homes. If the response is positive, then the agency may suggest a child with HIV disease to prospective adoptive parents and may place HIV-infected children in such foster homes. It is essential that the caseworker make a diligent effort to ascertain from the foster or prospective adoptive parents their attitude toward and capacity for caring for an HIV-infected child prior to placement; in no case should a foster parent or prospective adoptive parent be surprised with such information following a placement if that information is known at the time of placement. Nor should persons with a casual and general interest in adoption or foster care be provided with HIV-related information about a particular child.

However, when the agency is certain that the foster parents and prospective adoptive parents are willing to accept such children, the complete medical history, including HIV-related information, must be provided to them.

B. Medical History Documentation and Record Keeping

For each child in foster care the authorized agency caring for the child must maintain a continuing individual medical history in the uniform case record. If the child-caring agency is a voluntary agency, copies of additions to the medical history file must be forwarded to the social services district which has ultimate responsibility for the child's welfare whenever a significant change occurs in a child's health status or treatment, but in no case later than the next six month case review and reassessment.

Such changes might include hospitalization, emergency treatment, diagnostic testing, or necessity for extended follow-up care.

Locally established written procedures must ensure that social services district foster care staff provide any medical or health-related information in the uniform case record as requested by the Medical Assistance and C/THP Units of the agency. Such cooperative communication procedures are necessary to assure that all medical service requirements for the child are met.

The comprehensive health history of each child must include, but is not limited to, the following, where known:

1. hereditary conditions or diseases;
2. drugs or medications taken by the child's mother during pregnancy;
3. immunizations received by the child (type and dates);
4. medications dispensed to the child;
5. allergies exhibited by the child;
6. results of diagnostic tests and evaluations, including developmental and psychological tests, given to the child;
7. results of laboratory tests, including tests for HIV;
8. names and addresses of the child's health/medical provider(s);
9. follow-up or continuing treatment provided to, or still needed by, the child;

10. medical equipment/adaptive devices currently used or required by the child (e.g., wheelchair, feeding pump, mechanical breathing supports, eyeglasses, hearing aids).

In addition, the following forms and notices must be included in the health history section of the uniform case record:

1. Past medical records of the child. Diligent effort must be made to obtain records of any previous medical, psychological, or dental treatment of the child placed in foster care. Prior to accepting a child into care, or within 10 days after admission, a request must be made to the child's parent or guardian for written authorization for release of the child's past medical records. In the absence of parental consent, the local social services commissioner is authorized to sign the request for release of such records. Written requests with attached release authorization for the child's treatment history and records must be sent to known medical providers who have treated the child.
2. Form DSS 711, Child's Medical Record, or copies of a comparable medical record form. Some agencies prefer to provide an alternative form, and many physicians have designed forms for their own use. Any such forms are acceptable as long as they record the results of the initial and periodic medical examinations given the child. Form DSS 711 is available from NYSDSS Forms and Publications or through your local social services district office.
3. Form DSS 704, Medical Report on Mother and Infant. This form must be submitted to the appropriate hospital or physician with a request for all pre-natal and birth information available for each pre-school child placed in foster care. A consent release (see B.1.) must be attached. Diligent effort must be made to obtain such information, and all such information received, in whatever form, should be attached to Form 704 and retained in the case file.
4. Progress Notes. Form DSS-3306 is the official cover sheet for progress notes in the uniform case record. Any comparable form may be used to record information summarizing medical/health history-related activities. Activities which must be noted include the dates of medical and dental appointments, examinations and services, a record of referrals, follow-up activities, and transportation provided by the authorized agency. It is not necessary to summarize the child's medical record or results of examinations since the examination record forms must be retained in the same file.
5. Consent forms. At the time a child is placed in foster care voluntarily, the agency must request during the admission process, or within 10 calendar days after admission, an

authorization in writing from the child's parent or guardian for medical or psychological assessment, examination, and treatment, and for emergency medical or surgical care in case the parent or guardian cannot be located at the time the care is necessary.

At the same time, request must be made to the parent(s) for authorization for release of medical records from providers who have previously treated the child.

In cases of involuntary placement involving an abused, abandoned, or neglected child, if parental consent is not available, the local social services commissioner may provide both written authorizations for treatment and for release of medical records. According to Section 383-b of Social Services Law, "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."

In all cases the signed consent forms must be retained in the uniform case record with other items on the child's health history.

6. Family planning notices to foster parents. A copy must be kept in the child's health history file to indicate that the required notice of family planning services has been sent within 30 days of placement to all foster parents caring for children 12 years of age or older. This notice, which must also be sent annually to such foster parents, informs them of the availability of social, educational, and medical family planning services for the adolescent as is required by section 463.2 of Department regulations.

7. Notice of family planning services directly to adolescents (optional). If the local social services commissioner has approved a district-wide plan to make an offer directly to all foster care adolescents within his or her jurisdiction of family planning services, then a copy of the information provided to the child must be retained in the health history file. The availability of such services may be discussed orally with the young person, but must also be offered in writing. A policy to make such direct offers of services is a local option, but the established policy must have district-wide implementation.

8. Notice of C/THP services. Within 60 days of entry into foster care of a Medicaid-eligible child, the local department of social services must notify in writing the foster parents, or the institution, group residence, group home, or agency boarding

home of the availability of Child/Teen Health Plan (C/THP) services. A copy of the notice must be kept in the child's health history file. This written notice must also be provided to the caretakers of the child at least annually as required by Section 508.4(a) of Department regulations.

9. Child Care Review Service (CCRS). Data related to the foster child's appointments for medical, psychological, and/or dental examinations and treatment must be entered into the Child Care Review Service (CCRS) system in a timely manner. The dates and types of exams must be entered in order to track required timeframes for both the initial and periodic examinations. This computerized record will serve as an administrative tool to cue workers for scheduling purposes. It is not intended as a sanctionable requirement, but may be used for future reviews and reports.

C. The Initial Medical Examination

1. Each child entering foster care must be given an initial comprehensive medical examination no later than 30 days after admission. This requirement also applies to children returning to foster care after a period of 90 days following discharge, trial discharge, or absence without consent.

EXCEPTION: The initial comprehensive medical examination may be waived if the child has been given such an examination within 90 days prior to admission into foster care, records are obtained to document the examination, and the child's health status does not warrant a second comprehensive examination.

2. The initial comprehensive medical examination is optional when a child returns to care within 90 days after discharge, trial discharge, or absence without consent. However, in making such a decision, a careful assessment should be made of the child's previous history and current condition. Such an examination is also optional when a child is transferred from one agency to the care of another agency.

3. For each foster child's initial medical examination, the local social services district or voluntary agency is responsible for:

- a. scheduling the examination for the child or assisting the foster parent to schedule within the required timeframe;
- b. offering to provide or arrange for transportation as needed;

- c. providing the physician with the child's available medical history at the time of the exam or as soon thereafter as possible;
- d. ensuring that the physician is familiar with the requirements for a comprehensive examination (see IV.E.);
- e. ensuring that the examination is completed in those situations when the foster parent assumes responsibility for scheduling and taking the child to the examination without the caseworker;
- f. ensuring that the results of the initial examination and any referrals for follow-up care are retained in the child's health history file in the uniform case record. The date of the initial examination must be entered into the Child Care Review Services (see V.A.).

D. Periodic Medical Examinations

1. Every child in foster care must receive complete periodic individualized medical examinations on a continuing schedule. The required foster care periodic schedule is the same as that required by the Child/Teen Health Plan (C/THP) and follows the recommendation of the American Academy of Pediatrics of the American Medical Association. It is a standard for basic health care for all children, but each child's health care needs beyond this basic care must be met on a case-by-case assessment.

Examinations must follow current recommended medical practice and cover the requirements listed in IV. E. below. Agencies must ensure that children are examined according to the following schedule:

Age 0-1 year: 2-4 weeks / 2-3 months / 4-5 months / 6-7 months / 9-10 months

Age 1-6 years: 12-13 months / 14-15 months / 16-19 months / 23-25 months / 3 years / 4 years / 5 years

Age 6-21 years: 6-7 years / 8-9 years / 10-11 years / 12-13 years / 14-15 years / 16-17 years / 18-19 years / 20 years

2. Every foster child 3 years of age or older must have an annual dental examination by a dentist and must be provided with any other dental care as needed.

3. Authorized agencies must inform foster parents that assistance is available in scheduling appointments and providing or arranging for transportation to medical providers.

4. Records on the results of such examination, referrals for follow-up care, and casework activities related to scheduling these examinations must all be kept in the uniform case record as items in the child's health history file. Dates of such examinations must be entered into the Child Care Review Service system in a timely manner to maintain current information.

E. Contents of Comprehensive Medical Examinations

Medical examinations must take into account the age, environmental background and development of the child and must include the following:

1. a comprehensive health and developmental history;
2. a comprehensive unclothed physical examination;
3. an assessment of the child's immunization status and the provision of immunizations as necessary;
4. an appropriate vision assessment;
5. an appropriate hearing assessment;
6. laboratory tests as appropriate for specific age groups or because the child presents a history or symptoms indicating such tests are necessary;
7. dental 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
8. observation for child abuse and maltreatment which, if suspected, must be reported to the State Central Register of Child Abuse and Maltreatment.

These requirements follow current medical guidelines developed by the American Academy of Pediatrics.

F. Follow-Up Services

Agencies must ensure that follow-up health care is provided or arranged for each foster child as needed or recommended by the child's physician. Staff must consult with medical and other appropriate professionals and the child's foster parents regarding health services necessary to meet the child's needs. Written procedures must be developed locally to ensure that foster care services and Medical

Assistance staff, including Child/Teen Health Plan staff, cooperate and communicate in regard to their shared responsibility for follow-up services.

Following each comprehensive medical examination, agency staff must:

1. review the child's medical examination record form to determine whether the physician recommended further treatment, referrals, medications, or other follow-up care;
2. contact the medical provider as appropriate to obtain necessary information on follow-up care and treatment;
3. offer assistance to the foster parent(s) in arranging for follow-up care and transportation as necessary;
4. in cases requiring ongoing medical care, encourage the medical provider to contact the agency caring for the child concerning follow-up, referrals, missed appointments, or other important information.

G. Discharge from Foster Care

1. When a child is discharged from foster care, the comprehensive health history of the child must be provided:
  - a. to the child's parents or guardian if the child is released to their care; or
  - b. to the child himself or herself if the child is discharged to independent living.
2. Prior to final discharge agency staff must:
  - a. assist the parent(s) and/or child with interpretation of the health history;
  - b. discuss with the child's parents or the child to be discharged to his or her own care the importance of periodic medical assessments, follow-up treatments, and any medications prescribed by the physician;
  - c. discuss with the child's parents or the child to be discharged to his or her own care the availability of Child/Teen Health Plan (C/THP) services and eligibility for Medicaid;
  - d. assist the child's parents or the child to find a physician or medical provider organization in an appropriate

location through referrals and/or medical provider lists which must be maintained by social services Medical Assistance units;

e. make diligent effort to obtain the name and address of the child's post-discharge medical provider in order to provide the child's comprehensive health history to that provider.

3. Prior to discharge to independent living, a child must be given a comprehensive medical examination unless such an examination has been provided within one year of the date of discharge.

4. When a child is freed for adoption and is to be discharged from foster care to adoptive placement, a comprehensive medical examination must be provided unless such an examination has been given within 6 months prior to the adoptive placement.

## V. SYSTEMS IMPLICATIONS

### A. CCRS Reporting

1. To provide administrative assistance in the monitoring of required periodic medical examinations, local agencies must report to CCRS that the required medical examinations have been performed.

When the medical exam has been completed, the following CCRS activity code must be entered for each child in the prescribed manner:

H100 - MEDICAL EXAM PERFORMED. The activity date is the date the medical exam was done. There are no modifiers required. The entry of the H100 activity will release/suppress all prior cues for examinations that may not have been performed.

2. Within one year prior to the anticipated date of discharge for a child with a permanency planning goal of 03 - Discharge to Independent Living or 10 - Independent Living - Unaccompanied Refugee Only, a medical examination is necessary. When the PPG of 03 or 10 is entered on the assessment service plan, districts should also enter the anticipated completion date for the permanency planning goal of 03 - Discharge to Independent Living or 10 - Independent Living - Unaccompanied Refugee Only. In the future, a cue/notice will be generated six months prior to the anticipated completion date for any child with a PPG of 03 or 10 to assist districts in monitoring this requirement.

B. CCRS Caseload Report

To assist agencies in the management of medical exams for children in foster care, two additional cues/notices will appear on the CCRS Caseload Report. The cues are A660 - Medical Exam Due and C660 - Medical Exam Overdue. These cues will be generated for the following situations:

1. When the child is placed in foster care, the initial medical examination cue will be generated from the movement activity (M910), placement in care, reported to CCRS.
2. When the child has been absent from foster care for 91 days or more, the initial medical exam cue will be generated when the movement activity, "return to care," is reported to CCRS.

PLEASE NOTE: The movement activities must be reported to CCRS in the month in which they occur in order for the cues to be displayed on the appropriate month's report.

3. Periodic cues based on the date of birth of the foster child will be generated based on the schedule detailed in section IV. D, Periodic Medical Examinations, in this Directive.

C. Conversion

Six months from the effective date of this Directive, districts must have completed the following actions:

1. Entry of all appropriate H100 - Medical Exam Performed codes into CCRS activities. Only the most recent exam should be reported.
2. For each child with a PPG of 03 or 10, enter the anticipated completion date for the PPG.

VI. ADDITIONAL INFORMATION

A. Medical Assistance Eligibility

Local social services departments must determine Medical Assistance eligibility when a child is placed in foster care. Medical Assistance eligibility for children placed in foster care who are not eligible for and in receipt of Title IV-E foster care maintenance payments must be determined as described in 75 ADM-85 and 81 ADM-10. In accordance with 81 ADM-10, a child's Medical Assistance eligibility must be determined as a separate household of one, and must be based solely on the child's own income and resources and on the amount of support the parents contribute. The child's Medical Assistance eligibility level equals the foster care rate or the Medicaid level for a household of

one, whichever is higher. Children who are eligible for and in receipt of Title IV-E foster care maintenance payments are automatically eligible for Medical Assistance. (See 84 ADM-4.) Furthermore, all children who are eligible for Medical Assistance are entitled to receive Child/Teen Health Plan (C/THP) services.

B. Costs of Medical Examinations

Costs of medical examinations for all those children who are eligible for Medical Assistance, if not included in a voluntary agency's per diem child caring rates, will be paid through MMIS. Costs of examinations for children who are not eligible for Medical Assistance should be paid by the local district and claimed on Schedule K as federally non-participating (FNP) on line 4a or 4b, whichever is applicable.

C. Allocation of Program Costs

Appropriate reporting and allocation of program costs should follow directions specified in the Standards of Payment for Foster Care of Children Program Manual.

D. Annual Establishment of Medicaid Rates for Child Care Agencies

The Department will, on an annual basis, review agency reports of costs incurred in the delivery of medical services to children in care in order to determine the per diem rates for the subsequent year. Rates will be based on reasonable costs incurred in comparison to programs of similar type and geographic location, trended forward to reflect changes in prices for similar medical services.

VII. EFFECTIVE DATE

The effective date of the actions required by this Directive is August 1, 1990, retroactive to January 13, 1989, the date the regulations concerning medical services to children in foster care became effective.

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Joseph Semidei  
Deputy Commissioner  
Division of Family and  
Children Services



David A. Paterson  
Governor

NEW YORK STATE  
OFFICE OF CHILDREN & FAMILY SERVICES  
52 WASHINGTON STREET  
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Gladys Carrión, Esq.  
Commissioner

### Informational Letter

<b>Transmittal:</b>	09-OCFS-INF-01
<b>To:</b>	Commissioners of Social Services Executive Directors of Voluntary Authorized Agencies
<b>Issuing Division/Office:</b>	Strategic Planning and Policy Development
<b>Date:</b>	January 16, 2009
<b>Subject:</b>	<b>Health Care Coordination for Children in Foster Care: Approaches and Benefits</b>
<b>Suggested Distribution:</b>	Directors of Social Services Foster Care Supervisors Medical Directors Health Services Staff
<b>Contact Person(s):</b>	Any questions concerning this release should be directed to the appropriate Regional Office: Buffalo Regional Office – Mary Miller (716) 847-3145 <a href="mailto:Mary.Miller@ocfs.state.ny.us">Mary.Miller@ocfs.state.ny.us</a> Rochester Regional Office – Linda Kurtz (585) 238-8201 <a href="mailto:Linda.Kurtz@ocfs.state.ny.us">Linda.Kurtz@ocfs.state.ny.us</a> Syracuse Regional Office – Jack Klump (315) 423-1200 <a href="mailto:Jack.Klump@ocfs.state.ny.us">Jack.Klump@ocfs.state.ny.us</a> Albany Regional Office – Kerri Barber (518) 486-7078 <a href="mailto:Kerri.Barber@ocfs.state.ny.us">Kerri.Barber@ocfs.state.ny.us</a> Spring Valley Regional Office – Pat Sheehy (845) 708-2498 <a href="mailto:Patricia.Sheehy@ocfs.state.ny.us">Patricia.Sheehy@ocfs.state.ny.us</a> NYC Regional Office – Patricia Beresford (212) 383-1788 <a href="mailto:Patricia.Beresford@ocfs.state.ny.us">Patricia.Beresford@ocfs.state.ny.us</a> Native American Services – Kim Thomas (716) 847- 3123 <a href="mailto:Kim.Thomas@ocfs.state.ny.us">Kim.Thomas@ocfs.state.ny.us</a>
<b>Attachments:</b>	Yes
<b>Attachment Available Online:</b>	Yes

## Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
				Working Together: Health Services for Children in Foster Care	The New York State Care Coordination Pilot Project: Process & Impact Evaluation Study

### I. Purpose

The purpose of this Informational Letter is to transmit to social services districts and voluntary authorized agencies a practice guidance paper, “Health Care Coordination for Children in Foster Care: Approaches and Benefits.” This paper, developed by the Office of Children & Family Services (OCFS) in conjunction with Welfare Research Incorporated (WRI), describes the lessons learned during a four-year pilot project and provides social services districts and voluntary authorized agencies with useful information regarding health care coordination for children in foster care. The pilot and its evaluation were supported with Child Welfare Quality Enhancement Funds.

### II. Background

Children who enter foster care are more likely than other children to have a wide array of health care needs and issues. With changes in placement, the use of numerous medical providers and emergency rooms, occasionally incomplete information on health care prior to placement, and multiple demands on foster care caseworkers, meeting the health care needs of these children can become a serious challenge. To address these issues, the American Academy of Pediatrics and The Child Welfare League of America recommend that child welfare agencies adopt a care coordination approach to the health assessment, treatment, and follow-up of children residing in foster care.

In an effort to enhance the child welfare system’s capacity to identify and address the health-related needs of children in foster care, OCFS developed a pilot project to support the creation of health care coordination programs in eight service providers around the state. Funded sites were selected to reflect the various geographical areas, levels of care, health service delivery models, and authorized agencies that make up the foster care system in New York. The participating agencies determined how to implement care coordination within their existing structures. The attached paper describes their experiences, the benefits and challenges they addressed, and includes recommendations for putting care coordination into practice.

The New York State Care Coordination Pilot Project – Process & Impact Evaluation Study Findings is available at: <http://www.ocfs.state.ny.us/main/reports/>

**III. Program Implications**

The attached guidance document discusses staffing and service delivery considerations, and key elements to a successful care coordination program. It also provides suggestions for initiating implementation of care coordination on a limited scale.

OCFS is sharing this for local districts' and authorized agencies' information and use as you review current processes for coordination and oversight of health services for children in foster care.

*/s/ Nancy W. Martinez*

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**Issued By:**

Name: Nancy W. Martinez

Title: Director

Division/Office: Strategic Planning and Policy Development

Health Care  
Coordination for  
Children in Foster  
Care: Approaches  
and Benefits

A White Paper

New York State Office  
of Children and Family Services

**January 2009**

# Health Care Coordination for Children in Foster Care

## Acknowledgments

The New York State Office of Children and Family Services (OCFS) would like to thank the following agencies for their contribution to this project:

Abbott House

Catholic Guardian Society and Home Bureau

Child and Adolescent Treatment Services, Inc.

Episcopal Social Services

Erie County Department of Social Services

Green Chimneys Children's Services

The House of the Good Shepherd

Kinship Family and Children's Services

St. Vincent's Services, Inc.

Mary Skidmore, Bureau of Planning and Intervention Design, Strategic Planning and Policy Development, OCFS, coordinated the development of this White Paper.

Welfare Research, Inc. (WRI) provided writing and design assistance.

# Health Care Coordination for Children in Foster Care

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In this White Paper, the Office of Children and Family Services (OCFS) provides guidance to agencies in the creation and implementation of a health care coordination approach for children in foster care. Health includes all aspects of the child’s well-being—physical, dental, developmental, and mental health. The paper defines health care coordination and briefly describes models used in other states and in specific agency programs in New York State. In accordance with standards adopted by New York State and widely accepted in the child welfare field, OCFS recommends that all agencies incorporate a health care coordination approach in their provision of health services to children in foster care.

“Since implementing our enhanced health care coordination project, we have experienced a marked improvement in communication with mental health, developmental, and educational services, and better responsiveness of these service providers to the needs of the children. The health care coordinators are very knowledgeable about these systems, and how to access services that optimally match the particular needs of each child.”

*Abbott House*

## 1. Introduction

### Overview

Coordination of health care is a valuable service for everyone. Given the segmented system of care currently prevalent in the United States, coordinating the services provided by more than one doctor or other health care professional can present a significant challenge. In the child welfare system, however, health care coordination is not only critical but also attainable. Built into the system of agency and court oversight are opportunities for care coordination not available in the general population. Along with case management, service planning, and permanency planning, health care coordination can and should be provided.

In child welfare, the overall purpose of health care coordination is to coordinate children’s health care needs and services within the context of foster care placement and agency efforts to enhance the safety and well-being of children and plan for their permanency. As such, health care coordination plays a supportive role in service planning and permanency planning for children—a role that is increasingly valued as children come into placement with multiple physical, emotional, and developmental needs. This role is emphasized by the American Academy of Pediatrics (AAP) in *Fostering Health: Health Care for Children and Adolescents in Foster Care* (2005).

Children who are removed from their homes often enter the foster care system with multiple and sometimes complex health-related needs. Because of their experiences, they may have serious emotional, mental health, and behavioral problems. They generally have higher rates of developmental delays and physical disabilities than children not placed outside their homes.

Given the diversity and range of their medical needs, children in foster care may receive assessment and treatment from a number of health care providers, or their needs may be overlooked, and they may not receive necessary services. The function of health care coordination is to manage all of the child’s

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health-related needs and issues including mental health, developmental, and substance abuse issues. This paper provides suggestions on how agencies may wish to integrate this function into their program.

### What is health care coordination?

To promote optimal health of children in foster care, health care professionals, casework staff, agency staff, caregivers, birth parents, and service providers should work collaboratively toward implementing an integrated plan of care. To make this happen effectively, the function of health care coordination is crucial. Health care coordination is a series of activities that support oversight and responsibility for all aspects of health services for children in foster care.

The role of health care coordination is important so that: each child receives all necessary medical, developmental, mental health, dental, and substance abuse assessments in the specified time frames while in foster care; the foster family / caregiver supports the medical plan for the child; and information is shared appropriately among professionals involved in the child's care. Key health care coordinator activities include: collecting and updating health information, accessing and coordinating health services, health education, discharge planning, and facilitating communication between families and health care professionals.

Specific activities of health care coordinators may include the following:

- Collect information on a child/family's health history.
- Establish and maintain a comprehensive and up-to-date medical file.
- Obtain medical consent(s) as needed.
- Establish a medical home for the child (i.e., an established, ongoing relationship with a primary health care provider).
- Schedule and oversee the completion of medical, dental, developmental, mental health, and substance abuse assessments at foster care intake.
- Obtain any necessary and appropriate follow-up evaluations and services.
- Obtain documentation from health service providers for the child's medical file.
- Record current and ongoing health status and activities.
- Establish service relationships with health care providers.
- Coordinate and monitor ongoing health-related services.
- Communicate the results of initial assessments and ongoing health care treatment with the child's primary care provider, case manager, and other relevant service professionals, as authorized.
- Educate the child, birth parent / guardian, and foster family / caregiver about a child's health needs and issues, as authorized.

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- Coordinate treatment team meetings with caseworker, supervisors, agency health staff, childcare staff, and caregivers as appropriate.
- Facilitate the development and incorporation of health-related goals in the child's Family Assessment and Service Plan (FASP).
- Compile health, mental health, developmental, and substance abuse information for the court.
- Communicate with schools regarding the health and developmental needs of the child, as authorized.
- Develop a discharge plan and establish a medical home (*see above*) for children preparing to exit foster care.

Care coordinators accomplish many of these functions by working closely with child welfare staff, specifically case managers (caseworkers) and the child's medical home and other providers. Communication with case managers is integral to providing information and guidance on health-related matters to reach the goals of safety, well-being, and permanency for children in foster care. Although health care coordination may be conducted by a variety of individuals, it is recommended that a lead person with a health background be identified to provide or assist with health care coordination (*see section 4, Guidance for Agencies Implementing Health Care Coordination*).

### What Does Health Care Coordination Look Like?

What health care coordination looks like depends on the agency and its characteristics: its mission, purpose, structure, resources, and community. Although health care coordination encompasses certain common activities, the way it is implemented can vary tremendously. The "what" is generally the same; the "how" differs depending on particular circumstances. This is good news in terms of implementing health care coordination statewide: agencies have the flexibility of designing a model that meets their needs.

Section 2 of this paper briefly describes models of health care coordination that have been used in other states.

Section 3 addresses the implementation of a four-year health care coordination pilot in eight sites supported by OCFS from 2003 to 2007. As will be apparent, each agency funded by the project designed a different model depending on the agency's foster care programs, staffing, and ages and characteristics of children in care.

Section 4 provides guidance to agencies in implementing health care coordination.

# Health Care Coordination for Children in Foster Care

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## 2. Health Care Coordination Models in Other States

Health care coordination has also been implemented in other states, including California, Colorado, Connecticut, Massachusetts, Michigan, New Hampshire, New Jersey, and Wyoming. This section summarizes the efforts in four of these states.

In California, a public health nurse provides care coordination, within county child welfare service agencies and probation departments, under the supervision of a public health nurse manager. The local Child Health and Disability Prevention (CHDP) program is responsible for the administration of the Health Care Program for Children in Foster Care. The public health nurse works to ensure that the medical, mental health, dental, and developmental needs of those in foster care are being met. In addition, the public health nurse also collaborates and consults with the foster care team, including social workers and probation officers, in order to provide specialty services as well as comprehensive care.

Through Colorado's Department of Public Health and Environment's Health Care Program for Children with Special Needs, health care coordination has been implemented in 41 local and 14 regional public health agencies. A multidisciplinary team of health care coordinators includes community health nurses, social workers, family advocates, speech pathologists, registered dietitians, and a variety of other specialties. The health care coordination team assesses the child's medical and educational needs and then works with the family to produce a plan for care coordination. As the plan is implemented, the team monitors and evaluates the effectiveness of the plan to determine if desired outcomes have been reached.

In New Hampshire, the Department of Health and Human Services district offices have nurse coordinators on staff to ensure that children in foster care and relative home placement are receiving appropriate medical, dental, and mental health care. The nurse coordinator acts as a liaison between those who are involved with the health care needs of the child. This includes all those who are concerned with the safety of the child, including the child's birth and foster family, the child protection service worker, the juvenile probation and parole officer, and the medical community. The nurse coordinator assesses the child's past and current health status in a health care planning meeting and determines the best way to implement the ongoing health care of the child by coordinating both immediate and long-term care.

New Jersey began implementation of mini-health units in each of the local Division of Youth and Family Services offices in 2007 for children in out-of-home placement. Run by nurses, these mini-health units are charged with coordinating medical scheduling, participating in visits and meetings with families and their children, and collecting health records. The health units schedule appointments for initial medical exams, coordinate medical and mental health assessments, and monitor follow-up appointments. Further, they work to ensure continuity of care, which includes continuing care with the child's provider prior to placement, if possible; maintaining a single medical home for the child throughout placement; and ensuring a smooth transition after permanency has been achieved.

# Health Care Coordination for Children in Foster Care

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## 3. Health Care Coordination Approaches in New York State

### New York State Care Coordination Pilot Project

In an effort to enhance the child welfare system's capacity to identify and address the health-related needs of children in foster care, OCFS developed a pilot project to support the creation of health care coordination programs in eight service providers around the state. Initiated in 2003, these programs sought to improve the health, well-being, and permanency of children living in foster care by designating a particular individual (i.e., a care coordinator) or set of individuals to monitor, coordinate, and facilitate all aspects of a child's health care while in foster care.

Sites were selected to reflect the various geographic areas, levels of care, health service delivery models, and authorized agencies that make up the foster care system in New York State. OCFS provided a conceptual framework and mandatory outcomes for the project, but agencies were expected to work out the details of operationalizing health care coordination within their existing structures. In this way, pilot agencies have paved the road for the implementation of care coordination in other agencies.

Although specific models and operating procedures varied across the selected sites, each of the sponsored programs was designed to enhance the comprehensive identification of children's health problems, timely access to necessary programs and services, health education for staff and families, and communication among health professionals, service providers, and families. Long-term goals included reducing time to permanency and pregnancy prevention.

Participating agencies were: Abbott House, Catholic Guardian Society and Home Bureau, Child and Adolescent Treatment Services, Episcopal Social Services, Green Chimneys Children's Services, The House of the Good Shepherd, St. Vincent's Services, and Kinship Family and Youth Services. The Jewish Board of Family and Children's Services participated for one year.

Funds for the NYS Care Coordination Pilot Project were drawn from the OCFS-administered Quality Enhancement Fund (QEF), which uses Temporary Assistance for Needy Families (TANF) dollars to support the development and evaluation of innovative child welfare services aimed at promoting a family's ability to safely care for children in their own homes and preventing teen pregnancy. Pilot agencies were required to track activities in a database for evaluation purposes.

### Anticipated Benefits of Health Care Coordination

The thinking behind the pilot project was that the anticipated benefits from providing health care coordination would be both short-term and long-term. When care coordinators have the management of children's health-related needs and issues as their primary responsibility, they can devote the time needed to arrange and monitor health and health education services, with the goal of identifying and appropriately treating children's health-related issues. Regular, repeated contact with treatment providers may also facilitate the establishment of strong working relationships between a care coordinator and local health care professionals, potentially facilitating timely access to services. Thus, anticipated short-term benefits included:

- an increased likelihood that a child will receive a full array of comprehensive health-related assessments at foster care intake;
- better identification and documentation of health care needs;

## Health Care Coordination for Children in Foster Care

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- more timely access to health care and service providers; and
- increased education of and communication among birth parents, caregivers, and service providers regarding a child's health needs and services.

It was felt that improvement of the overall health and well-being of children resulting from the short-term benefits may in the long run promote permanency. Potential long-term benefits included:

- decrease in changes in foster care placement due to fewer demands placed on caregivers;
- reduction in time in placement due to education of birth parents/caregivers about a child's health needs and involvement of family members in the child's health care, addressing a possible barrier to reunification; and
- reduction of risky behavior and teenage pregnancy due to increased access to health education, reproductive services (family planning, gynecological care, etc.), and mental health and/or substance abuse services.

### Program Settings, Staffing, and Models

While each participating program served children placed into foster care as a result of child abuse and neglect, the level of foster care in the eight participating sites ranged from regular foster boarding homes to institutional settings. Other differences included: environment (rural, urban), location (upstate or NYC), size and staffing, facility resources, and health services delivery systems. The main characteristics of each program are displayed in the chart on the next page.

The qualifications of care coordinators also differed across sites. Requirements set by the individual agencies for their care coordination staff included: Registered Nurse (RN), Licensed Practical Nurse (LPN), Bachelor of Arts (BA), Master of Arts (MA), Master of Science in Education (MSED), Master of Social Work (MSW), and Master of Public Health (MPH). One agency used foreign-licensed physicians in the process of obtaining licensure in the United States.

To help promote the development of programs that were responsive to local needs and issues, OCFS encouraged the agencies to develop the service delivery model best suited to their target population, staffing resources, and existing operational structure. As a result, each of the eight models in the pilot project is unique. Each reflects the agency's characteristics as well as the creativity and energy of the agency's staff.

“The Care Coordinator has allowed for an additional layer of oversight, and central point of Health information. This has improved communication among the Treatment Team.... As the Care Coordinator has shared her experience with the Social Services department and other clinical and campus staff, there is an increased awareness among staff about medical issues present in our client population.”

*Green Chimneys Children's Services*

## Health Care Coordination for Children in Foster Care

Agency Settings & Staffing			
Agency	Setting	Health Services Delivery	Care Coordinator Qualifications & Caseloads
<b>Abbott House</b>	Bronx Regular agency-certified and kinship foster boarding homes Short-term diagnostic group homes	Neighborhood-based clinics and hospitals  Halfway through project, agency opened an on-site clinic for primary care	Experienced caseworkers with bachelor's degrees  Foster homes–1 FTE care coordinator for 35 children  Group homes–1 FTE care coordinator for 15 children
<b>Catholic Guardian Society and Home Bureau</b>	Manhattan, Bronx, Staten Island  Regular foster boarding homes–most children qualified for special or exceptional board rates  Mother/baby group homes	Community health providers	Medical social workers for foster care  Registered nurses for mother/baby homes  Foster homes–1 FTE care coordinator for 40 children  Mother/baby group homes–0.5 FTE care coordinator for 12 mothers and their babies
<b>Child and Adolescent Treatment Services</b>	Erie County–urban and suburban  Regular foster boarding homes	Medicaid managed care.  All foster children go to one medical home for primary care	Bachelor's or master's degree in social work or related field  1 FTE care coordinator for 30 to 45 children
<b>Episcopal Social Services</b>	Manhattan, Bronx  Special needs (medically fragile) foster boarding homes	On-site medical clinic for primary care, dental, mental health	Physicians trained outside of U.S.  0.5 FTE care coordinator for 13 children
<b>Green Chimneys Children's Services</b>	Putnam County–rural, close to New York City  Residential Treatment Center for young children	On-site medical clinic for primary care, developmental, dental, mental health	Master of Social Work  1 FTE care coordinator for 15–25 children
<b>The House of the Good Shepherd</b>	Oneida County–small city and rural  Therapeutic foster boarding homes  Residential Treatment Center	Foster boarding homes used community health providers  Residential Treatment Center used on-site clinic for primary care	Master of Social Work  Foster homes–1 FTE care coordinator for 30 children  Residential Treatment Center–1 FTE care coordinator for 30 children
<b>Kinship Family and Children's Services</b>	Steuben County–rural with children from many counties  Therapeutic foster boarding homes	Community health providers  Contract psychologist conducts all mental health assessments	Registered nurse  Master of Science in Education  2 FTE care coordinators for 30–40 children
<b>St. Vincent's Services</b>	Brooklyn  Regular foster boarding homes	On-site medical clinic for primary care, agency mental health and chemical dependency clinics	Medical social worker, registered nurse  2 FTE care coordinators for 60 children

## Health Care Coordination for Children in Foster Care

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Despite these differences in program setting and structure, which were evident in the applications for funding, the day-to-day functions of the care coordinator were expected to be similar across pilot sites. In all of the programs, care coordination staff were expected to work with the caseworker assigned to the child's family by the local social service agency, and to assume primary responsibility for managing all aspects of the child's health care.

Managing all aspects of the child's health care includes working with the child's primary care provider and any other health-related providers (mental health, developmental) as well as agency staff dealing with medical issues. Care coordinators were also expected to work closely with other providers such as the Early Intervention (EI) Services Coordinator for children up to three years old receiving EI services and the School Supportive Health Services Program for children with handicapping conditions receiving Committee on Special Education (CSE) services. As educational services and assessments are integral to other health issues, particularly for children with special needs, care coordinators became key liaisons between the agency and the child's school.

### Challenges

As with any new approach involving staffing and organizational considerations, challenges will occur in getting the program off the ground and keeping it going smoothly. The agencies participating in the pilot faced several challenges, some of which they shared but dealt with differently. Their challenges are much the same as those that might be experienced by any agency seeking to implement health care coordination effectively. Learning how agencies dealt with these challenges may be helpful to agencies implementing health care coordination.

This section briefly describes each agency in the pilot, the challenges faced by the agency or program, and the solutions used to deal with the challenges.

Primary challenges included:

- Clarifying the roles of the care coordinator
- Handling staff turnover and retention
- Establishing relationships with casework and supervisory staff
- Meeting the needs of children
- Gaining trust and involvement of birth parents
- Obtaining health records from providers
- Accomplishing data collection and input for the pilot

# Health Care Coordination for Children in Foster Care

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## Agencies and Their Solutions

### **Abbott House**

Abbott House provides several levels of foster care: foster boarding homes (FBH), including kinship and emergency; therapeutic foster boarding homes (TFBH), group homes, and a residential treatment center (RTC), as well as diagnostic reception centers. Abbott House serves metropolitan New York City and the surrounding counties. The main agency offices, located in Westchester County, have a medical department and dentist. However, it is not practical for foster parents in the Bronx to bring children there for care, so community health care services were used at the inception of the project.

Care coordinators were employed for the Bronx foster boarding home program initially, and later for the short-term, diagnostic group home program as well. Experienced, motivated foster care caseworkers were selected from existing staff for these positions. A nurse devoted part of her time to providing technical assistance to the care coordinators.

Even before participating in the pilot project, Abbott House had been providing health care coordination for children in its foster boarding homes, but there were challenges in fulfilling this function for children receiving health care services in the community. It was difficult for foster parents to access health care (e.g., for initial assessments) on a timely basis and there were problems from both sides (foster parents and providers) in obtaining medical documentation of appointments. Halfway through the project, it became apparent to the agency that there was a need for on-site services, and they opened a medical clinic in the Bronx office and contracted with a mobile dental van.

Some adjustments in staffing were made to fully integrate the health care coordination function into the programs at Abbott House. The care coordinators now took on the responsibilities for all medical, mental health, developmental, educational, and dental assessments and treatment. Since foster care caseworkers were previously responsible for these functions, they—along with foster parents and birth parents—were confused about the role of the care coordinator. “This adjustment within the organizational structure had an enormous impact on Abbott House and the children served within this project,” reported the medical director.

**Solutions:** The medical clinic and dental van provided the opportunity for a full health care coordination function to operate successfully and as a team (medical director, nurses, and health care coordinators). Establishing an on-site clinic addressed the two issues of access and documentation: the agency was now able to provide timely initial assessments and to schedule child/parent medical visits. Routine visitations between birth parents and their children were scheduled at the Bronx office for clinic days. This way, parents were able to attend the clinic appointments and learn about their child’s health needs without making an extra trip.

To clarify their roles, the care coordinators and caseworkers held weekly team meetings to update one another on their areas of responsibilities. Each child’s status was reviewed once a month. These team meetings became one of the most critical elements in the success of care coordination at Abbott House. To reduce any confusion among foster parents and birth parents, the care coordinators attended the 72-hour conference to introduce themselves and explain their role in the case. The care coordinator accompanied the caseworker on home visits to the foster parents and birth parents to speak about the health and educational needs of the children and support communication among the parents.

## Health Care Coordination for Children in Foster Care

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As an agency that contracts with the New York City Administration for Children's Services (ACS), Abbott House must comply with ACS requirements. The health care coordinators identified and used community providers that were willing to follow the rules and regulations set forth by ACS and provide the agency with necessary documentation. Mandated contacts with foster and birth parents were increased as a result of the care coordinators' involvement.

Abbott House will continue to use the health care coordination, incorporating the position into ACS' new Improved Outcomes for Children (IOC) model.

### **Catholic Guardian Society and Home Bureau**

In 2006, during the period of the pilot project, the former Catholic Guardian Society merged with Catholic Home Bureau, forming a large foster care agency offering foster family care and group homes along with supportive services primarily serving Manhattan and the Bronx through five community-based centers. The congregate care program serves youth in four boroughs.

Catholic Guardian's care coordination services were integrated into the agency's existing range of services, using such approaches as early engagement and intervention along with family involvement in services and planning. Most of the many tasks of care coordination were completed during interactions with birth parents, children, foster parents, child care staff, caseworkers/supervisors, and medical, mental health, and educational providers.

The care coordinators assigned to the mother-child group homes were experienced registered nurses who enjoyed the challenge of working with youth in foster care. The nurses conducted all initial assessments except mental health, which were completed by a psychologist.

The care coordinators assigned to the foster boarding home (FBH) program were medical social workers who worked closely with the nurse assigned to the cases on their caseload. This allowed for adequate monitoring and consultation on health and mental health issues with health care providers. Children selected for participation in the project were already in foster care, rather than new admissions. The care coordinators focused on working with the birth parents to increase their involvement with the children and capacity to bring them home.

**Solutions:** The establishment of a designated care coordinator supervisor at the Washington Heights site was instrumental in providing ongoing supervision of the care coordinators; monitoring so that all assessments were completed within the required time frame; and calling team meetings to discuss issues around case planning, problem-solving, and rectifying organizational problems such as staff shortages and turnover.

It took some time for staff and families in the Washington Heights site to understand the role of the care coordinator. Over time, the care coordinators were able to establish non-threatening relationships with birth parents: they advocated for birth parents, included them in decision-making, educated them on the health needs of their children, and helped them obtain medical and mental health services. The care coordinators complemented the caseworkers so that together they were effective in working with the children, foster parents, and birth parents. Foster parents were educated on the health needs of the children in their care, asked to attend all medical appointments, and encouraged to partner with the birth parents around medical care.

## Health Care Coordination for Children in Foster Care

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The most important challenge for the care coordinator for the mother/child group homes was to establish a relationship with the teen mothers. The coordinators used a variety of ways to build this relationship, including group meetings focused on activities with infants, nutrition, and safety in the home. The care coordinator encouraged expression of feelings and provided emotional support while teaching healthy behaviors in a nonjudgmental fashion. Fathers were encouraged to be involved. During the project, sexual acting out and subsequent pregnancies were significantly reduced.

Catholic Guardian Society and Home Bureau will continue to use the health care coordination model by incorporating the costs into their Medicaid per diem.

### **Child and Adolescent Treatment Services**

Unlike the other health care coordination contractors, Child and Adolescent Treatment Services (CATS) is not an authorized foster care agency. CATS is a community organization that provides counseling and treatment services in accessible, child-friendly offices throughout Erie County, as well as in schools and other community-based settings. The staff of multidisciplinary mental health professionals provides specialized programs for children with emotional disorders, victims of physical and sexual abuse, suicide prevention, and violence prevention, as well as guidance for parents. This care coordination model comprised an agreement between a Medicaid Managed Care Plan and a large urban county social services agency.

The care coordination program, known as Care4Kids, is a Medicaid Managed Care Plan under the auspices of CATS. Prior to this project, the Child Advocacy Center (CAC), also a part of CATS, conducted sexual abuse exams for chronically abused children, as well as pre-placement foster care physicals. Through Care4Kids, the CAC was established as the medical home for children in direct care with the Erie County Department of Social Services (DSS). Virtually all children entering foster care in Erie County receive comprehensive medical, dental, and behavioral health assessments through the CAC. With access to the agency's on-site medical and mental health professionals, the Care4Kids program could provide children in the pilot quality comprehensive medical care through 30-day follow-up examinations, improved recordkeeping, and a focus on the need for early mental health assessments.

**Solutions:** The most difficult challenge was clarifying the role between CATS and Erie County DSS. As an outside organization, CATS was providing services to children not directly in its care. At times, children were moved without notification to the care coordinator, contact information on birth parents was not available, and caseworkers did not understand the care coordinator's role in the service plan review. For this model of care coordination to succeed, a liaison is critical: Erie County DSS provided a liaison who helped implement the program and explained it to caseworkers and other DSS staff.

One staffing challenge involving delays in hiring a health care coordination supervisor was solved by reconfiguring the position from a nurse to a master's level human services candidate. Staff included two social workers (one a medical social worker), nurse manager, and a secretary.

Over time, as the care coordinators made connections with health care providers in the community, the children were more likely to be seen more quickly; as a result, foster parents overcame initial resistance to the "extra work" coming from the care coordinators and began to understand their role and see them as being supportive to them as well as to the children. Erie County caseworkers also began to be aware of and appreciate the work being done on behalf of the children in their caseload by care coordinators.

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Another challenge was the delay in Medicaid coverage for some of the foster children in the pilot. The delay caused problems in accessing necessary referrals for mental health counseling and other specialty care services such as vision and eye glasses. This was addressed by notifying Erie County DSS caseworkers of the delay.

Upon completion of the pilot project, the medical component of Care4Kids will continue in that all children entering foster care will receive a pre-placement physical and 30-day recheck at the Child Advocacy Center. If possible, Erie County DSS will pick up the care coordination component.

### **Episcopal Social Services**

Located in Manhattan and the Bronx, Episcopal Social Services offers foster care, adoption, and preventive services, group homes, Early Intervention services, and Early Head Start, among other programs. Two on-site medical clinics provide a comprehensive range of health services: pediatric medicine, child psychiatry, child psychology, dental services, and services for vision, hearing, sex education, and immunizations.

Because Episcopal Social Services made education of the caregivers and birth parents the overarching goal of their project, health care coordinators were called health educators. The children receiving care coordination services were medically fragile; some of the presenting problems included HIV infection, shaken baby syndrome, seizure disorder, diabetes, sickle-cell disease, autism, and cerebral palsy. Though primary pediatric care, including dental and mental health, was provided by agency clinics, these children needed care from medical specialists in the community. The health care coordinators served as liaisons between hospital staff and parents (birth and foster).

**Solutions:** To help prevent multiple transfers from one foster home to another, the families received close supervision and support. Birth parents and foster parents were given a thorough explanation of the children's conditions and provided the opportunity to ask questions and get answers. To increase health knowledge and engagement with the child, the health care coordinator insisted that foster parents go to all specialty appointments. The care coordinators worked closely with the social work staff, conducted monthly home visits, addressed language barriers, advocated for the children, and facilitated compliance with treatment recommendations.

The agency medical director, who is board certified in pediatrics and child psychiatry, occasionally called specialty physicians directly to break through bureaucratic barriers in obtaining necessary services for these children.

The most important challenge was to verify that each child was safe in an environment that allowed for personal growth and a healthy lifestyle. This challenge was addressed by providing education for caregivers and birth parents on the type of care needed for medically fragile children. When given a comprehensive understanding of the child's needs and the necessary skills to address those needs, foster parents have the confidence and support to maintain the placement, and birth parents can work toward the child's return home.

The care coordination model continued at the agency upon the pilot's end.

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### **Green Chimneys Children’s Services, Inc.**

Green Chimneys operates residential treatment for children and a special education school on a 200-acre farm in Brewster, NY. The agency offers specialized treatment and educational and recreational services to children in New York City, upstate New York, and western Connecticut. Using animal-assisted therapy, the Farm & Wildlife Rehabilitation Center is an important component of the treatment program. Green Chimneys provides extensive structure and support to children aged 5-13 (upon admission) with diagnoses such as Attention Deficit Hyperactivity Disorder (ADHD), Asperger’s Syndrome, Pervasive Developmental Disorder, Anxiety and Social Phobia, Post Traumatic Stress Disorder, Reactive Attachment Disorder, and Oppositional Defiant Disorder.

Through the project, an MSW became the health care coordinator for a group of 25 children with a high level of medical, mental health, and developmental needs. A population of mostly girls (aged 5 to 14) was identified for care coordination. Health care needs of the children are addressed on campus. The Health Center provides medical, dental, developmental, and mental health services for residents, and children attend an on-campus school. The care coordinator focused on communication issues. She provided a central point of health information, increased communication among the treatment team members, increased awareness among casework staff about medical issues, helped train clinical staff to work more effectively with families, and bridged the gap between school staff and cottage staff.

**Solutions:** Prior to implementation of care coordination, a social work model of care was in place. Each child was assigned a social worker who provided therapy, worked with the family, and completed caseworker duties. The care coordinator took over some of the duties that would typically be done by a caseworker, such as oversight of all medical and health services, liaison with ACS/DSS case planners, and discharge planning. The result was a dual track approach that clarified and defined roles. Social workers now provide family and group therapy, and caseworkers attend case conferences and provide other common casework functions.

To address the fact that because the agency had a higher population of boys than girls its services were geared more toward the needs of boys, the project brought a focus on activities that would encourage girls’ self-esteem. While living at home, many of these girls were exposed to domestic violence, witnessed sexual activity, and/or were victims of sexual abuse. Targeted activities provided them with appropriate role models, information on healthy development, and self-esteem.

Having a health care coordinator has also allowed for a clear role—a person that others can go to regarding coordination and communication between clinical/health staff, education staff, and caseworkers, as well as parents. The health care coordinator successfully opened lines of communication between the agency and their outside contractor for substance and “children of abusers” services. She provided feedback to the agency from the birth parents around issues of health care management. She also assisted in identifying the need for a different level of care when appropriate, and developed discharge plans.

The health care coordination model has continued at Green Chimneys.

### **The House of the Good Shepherd**

Located in Utica, The House of the Good Shepherd (HGS) provides residential care including a residential treatment center and group homes, as well as foster boarding homes and preventive services in the surrounding counties. The agency’s Health Department provides pediatric health services for children

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living on campus; a nurse coordinates health care with primary care providers in the community for children in foster boarding homes.

The care coordination project focused on the children who would be most likely to benefit from aggressive coordination of services. Children selected displayed evidence of serious mental health disorders or severe dysfunction. Two master's level social workers served as care coordinators—one for the therapeutic foster boarding home program and one for the Residential Treatment Center (RTC). These coordinators were responsible for a plan of care that ensured that services provided by a multi-disciplinary team of social work, educational, medical and residential staff or foster parents were delivered and communicated in a timely, organized, and coordinated fashion. Even though the youth in the RTC received health services on campus and the children in therapeutic foster care received care in the community, the care coordination functions were similar.

Like Green Chimneys, the House of the Good Shepherd used a “primary therapist” model, wherein one individual was responsible for all aspects of the child's treatment. Handing health concerns over to the new care coordinators was a significant change, but benefits to the therapist became quickly apparent.

**Solutions:** Although nursing and therapist staff had undertaken many of the care coordination tasks before the project began, the formalization of the care coordination roles resulted in a stronger program in delivering educational services such as pregnancy prevention (through a contract with Planned Parenthood) and substance abuse education. Weekly communication with service providers, attendance at treatment planning meetings, and supervision with staff were required so that service needs were met.

The RTC care coordinator initiated regular team meetings among the clinicians and residential supervisors that helped to address treatment challenges, increase communication and coordination, and provide greater opportunity for successfully maintaining stability in placement. As a result of the pilot project, treatment team supervisors now oversee the work of the therapists in the RTC.

While care coordination as described above did not continue after the pilot, it set the stage for more collaboration between clinical and social work aspects of treatment. The nurse practitioner now participates in treatment planning and is involved in many of the activities that had been completed by the care coordinator.

### **Kinship Family and Children's Services**

Kinship Family and Children's Services offers residential care, preventive services, therapeutic foster care, child health care, and parenting skills education throughout the rural Finger Lakes and Western Regions of New York State. The agency is a division of Catholic Charities of Rochester, Inc. Except for mental health services, which are available through contract, health services are provided in the community.

This is a small agency and children come from several surrounding counties. All children placed in the therapeutic foster boarding home program received care coordination services. Due to the geography in this area of the state, transportation to medical appointments was a challenge.

With the goal of providing services to children with severe mental health and behavioral needs living in therapeutic foster care, the RN care coordinator shared responsibility with an education specialist with a master of science in education (MSED) degree. Responsibilities were differentiated: the RN became responsible for coordination of services, documentation, tracking, and oversight of health services, while

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the education specialist focused on areas of special need such as special education and birth parent involvement.

**Solutions:** After some organizational adjustments, it became apparent that it would be more effective to divide the responsibilities between the RN and MSED staff. Rather than maintaining their own caseload, the two care coordinators worked collaboratively with all children in the program. This division of roles worked well to facilitate continuity of health care and sharing of accurate information with all involved in the children's care.

The challenge of documenting and tracking health services by agency staff, foster parents, and birth parents was addressed by frequent phone calls and reminder letters. Kinship developed a brief form that foster parents bring to medical appointments. The health provider fills it out and it becomes a record of the appointment. Samples of these forms can be found in the manual *Working Together: Health Services for Children in Foster Care* at [http://www.ocfs.state.ny.us/main/sppd/health\\_services/manual.asp](http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp)

Care coordinators were invited to attend weekly team meetings that reviewed placement referrals, new admissions, discharges, moves, and health-related issues. The care coordinators assisted in identifying appropriate placements for children coming into the agency. In one case, contact by the care coordinators resulted in a birth mother providing transportation to her daughter for health appointments while the child was in care. As a result, the mother was effectively engaged in family counseling and the child was discharged earlier. The project as a whole resulted in significant reductions in movement while in care and quicker discharges.

The care coordination team continued to serve the children at Kinship for another year after the pilot ended.

### St. Vincent's Services

St. Vincent's Services offers a broad array of services including foster care, group homes, a program for children with AIDS and other medically fragile conditions, a licensed mental health and chemical dependency clinic, and services for the developmentally disabled. The agency is located in Brooklyn and serves all of New York City.

The medical caseworker (social worker) and RN worked as a care coordination team to serve large sibling groups, teen mothers with their children, and adolescents. As the program progressed, children with more intense medical needs were added to the group served. They described their service population as those "children who are falling through the cracks." The associate director of the Medical Department directly coordinated the project and held weekly team meetings, which included data entry staff, who were integral to the project. Identified needs were to involve more birth parents in their children's health care, increase discharge planning services, better engage the teen population to prepare them to address their own health needs, and educate birth parents and foster parents on health care issues.

**Solutions:** Initially uncertain of the project's impact, eventually casework staff welcomed the interventions of the medical caseworker in several areas: decreasing the caseloads of existing staff, providing comprehensive case management to families and better quality of service including specialty care, and meeting mandated requirements.

Data entry staff handled documentation requirements and also helped the care coordination team to assess the service provided and identify needs.

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To enhance training of youth and parents, the project obtained a portable DVD to facilitate educational activities. A system was put in place for rescheduling missed appointments and providing follow-up, including a reward system. To encourage going to the dentist, the care coordinators initiated “dental dates” in which children were rewarded by going out to lunch or receiving special attention from staff in conjunction with their dental appointment.

The more intense case management provided resulted in many children feeling comfortable enough to reveal past sexual abuse, which could then be addressed. As with many agencies, St. Vincent’s found that heightened awareness and communication resulted in more identification and quicker intervention for health issues. Some children were transferred to the specialized medical program to provide a higher level of service.

St. Vincent’s is unable to maintain the intensity of case management in the pilot project. However, second year MSW students will become a part of the medical department.

### Benefits of Health Care Coordination in Pilot Programs

According to one pilot agency, “Overall, the significant benefit of enhanced health care coordination is a magnified focus on the health care issues of children in care, which has resulted in rapid identification of health needs and establishment of health services, improved communication among various entities (health and mental health providers, developmental and special education services, pediatric subspecialists), improved compliance of foster parents, and involvement of birth parents.”

The program evaluation of the pilot project documented the following program benefits:<sup>1</sup>

- Higher rates of initial assessment completion and timeliness. Following establishment of their care coordination programs, sponsored agencies significantly increased the number of children under their care who received initial physical, dental, mental health, developmental, and substance abuse assessments within state recommended time frames.
- Better identification of health care needs. Children were more likely to have documentation of physical, mental health, developmental and educational problems diagnosed and/or identified by a health care professional.
- Improved documentation of access to health care professionals. Documentation of well child care, preventive dental exams, mental health therapy, Individual Education Plans, and Early Intervention service receipt was significantly higher for children in care coordination.
- Increased communication with service providers and caregivers. Care coordination staff had more contact with birth parents, foster parents, and service providers about a child’s health-related needs than foster care staff working without health care coordination.

In addition to the evaluation findings, the pilot sites reported that enhanced attention to health services resulted in benefits at the institutional level. Participants were motivated to shift their broader agency culture to a more integrated, health-oriented model of service delivery. As a result, some agencies designed new mechanisms for gathering and tracking health care information; developed assessment

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1 NYS Office of Children & Family Services. *The New York State Care Coordination Pilot Project: Process & Impact Evaluation Study Findings* (March 2007). Available at <http://www.ocfs.state.ny.us/main/reports/>

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protocols for new admissions; enhanced parent education services; established agency-community provider partnerships; and established or improved on-site health facilities. Many agencies noted that the project was instrumental in identifying service gaps, preventing issues from falling through the cracks, and reducing duplication of effort. Care coordination staff also acted as a model for other agency staff, piloting and sharing new ways for addressing health issues.

Agencies found that health care coordinators served as an additional support to caseworkers and birth parents alike. Caseworkers became comfortable with care coordinators addressing all aspects of health care. Birth parents perceived the care coordinators as a nonthreatening resource within the agency. Trust was built between birth parents and care coordinators as both focused on the child's well-being and worked together to understand and support the child.

“Having a dedicated person (Care Coordinator) who can ‘shepherd’ and monitor the completion of evaluations and subsequent follow-ups has been particularly valuable in the physical health area. Our experience is that we have more timely completions of evaluations and a much tighter process of ensuring that follow-up treatments are provided. As an indirect result, we have also revised our physical health assessment form to be much more comprehensive and in line with the Working Together manual.”

*The House of the Good Shepherd*

### 4. Guidance for Agencies Implementing Health Care Coordination

Health care coordination will look different across New York State because of the variety of health service delivery models in our agencies and local departments of social services. In planning implementation, agencies should consider a variety of factors, including available resources. Two important factors to consider are how health services are delivered to children in foster care, and how the agency currently monitors or oversees the services.

#### Health Services Delivery

Children in foster care receive medical care in a variety of ways. Methods of communication and collaboration between the provider and care coordinator will differ across these models. Some typical health delivery models include:

- **Community providers.** Children in foster homes receive their care from providers within the community. These may include doctors and clinics that the foster parents or agency know to be reliable and familiar with the needs of children in foster care. Typically, the foster parent accompanies the child to the appointment, keeps track of appointments, and informs the caseworker about the outcome of the appointment.
- **Agreements with providers.** The LDSS or voluntary agency may have agreements or contracts with community or hospital-based providers to serve children in foster care. For example, a specific psychologist may contract with the agency to conduct all initial mental health assessments, or a mobile dental van may be engaged on a regular basis.

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- **Agency clinic.** The LDSS or agency may operate its own medical clinic for children in care. Children may still use community or hospital providers for specialty care.

### Oversight

The coordination, monitoring, and oversight of health services are dependent on the staffing model at the agency or LDSS with whom the child is placed, as well as the level of care. Identifying individuals who are currently carrying out the care coordination activities is an important step in determining what changes, if any, will take place. Typical oversight models:

- Foster parents may play a major role by scheduling appointments, accompanying the child to appointments, and advocating for specialty services. The foster parents keep the agency informed of health-related activities.
- The case manager or caseworker may be responsible for arranging and reminding caregivers of appointments, assisting with transportation, and obtaining copies of records.
- The agency may employ health care coordinators and/or nursing staff that track attendance at appointments and review records to determine what additional services are needed. This model is often employed in congregate care settings.

### Critical Elements

Although the models created varied, the pilot agencies agreed that certain activities were critical to the success of their health care coordination projects.

- **Designation of care coordinator.** The single most important factor in the success of health care coordination is the designation of an individual whose sole responsibility is care coordination. That person is freed from the many tasks, concerns, and responsibilities that foster care staff must address. The care coordinator can simply concentrate on the child's health and well-being.
- **Organizational support.** The decision to incorporate health care coordination for children in foster care must be supported by administrators and managers throughout the organization.
- **Clarification of roles.** Staff must understand which activities will now be performed by the care coordinator. Among other things, the care coordinator's role in service plan development and review, and working with foster and birth parents should be clearly defined.
- **Team meetings.** Pilot agencies found that regular team meetings with health care coordinators, caseworkers, supervisors, and in-house medical staff were instrumental in sharing information and fully integrating health issues into the child's service and permanency plans.

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## Activities That Benefit the Agency

Depending on the size, capacity, and experience of the staff responsible for health care coordination, additional support may be provided to the agency in a variety of ways. These include:

- Coordination of training efforts around health topics. Both caseworkers and caregivers need information about the unique health care needs of children in foster care. Community health providers may also appreciate information on child welfare issues to help them understand the children they are serving. Health care coordination serves a central role in identifying, arranging, and tracking the provision of health training and education.
- Consultation and advocacy on special medical issues.
- Assistance and support for the caseworker around special services such as Early Intervention (EI), Bridges to Health (B2H), or the Committee on Special Education (CSE). More information on these services can be found in the manual *Working Together: Health Services for Children in Foster Care*. [http://www.ocfs.state.ny.us/main/sppd/health\\_services/manual.asp](http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp)
- Documentation and update of agency protocols and procedures. These may address topics such as confidentiality, maintenance of the child's medical record, billing procedures for providers and emergency rooms, protocols around the use of psychiatric medications, or the development of specialized forms or systems for tracking health activities.
- Monitoring and evaluation of the overall quality of health services provided to children in foster care. This information can prove valuable in overcoming barriers to optimal health services. It can also inform management and local government on the strengths and areas for improvement in the local health care delivery system. State, county, and voluntary agencies should cooperate in the development and implementation of Quality Improvement Programs for health services for children in foster care.

## Getting Started

After consideration of the health services delivery model, current practice, and resources, your agency may choose to delegate some health care coordination activities to designated staff. It is recommended that a lead person with a health background be identified to provide or assist with health care coordination. This individual may be an RN, LPN, psychologist, LCSW, LMSW, or social worker with experience in addressing the physical and mental health needs of children in foster care. If the individual does not have training or experience in a health field, health practitioners should be identified to provide technical assistance.

A starting point allows for agencies to learn how this function would work in their environment and with their own model of health care delivery. Here are some suggestions for implementing care coordination on a limited scale:

- Start small. Have one care coordinator work with a couple of caseworkers in one unit with a supervisor that supports the concept.

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- Pilot agencies identified the population most likely to benefit from care coordination to be children in foster homes receiving health services in the community. Start with this group.
- Target only the neediest children. Identify children with the most complex health needs or those in a special program within your agency for care coordination.
- Target service gaps. If a specific issue has been identified, such as birth parents not understanding their children's health needs, focus care coordination on that issue.
- Limit the length of time that care coordination services are provided. Have the care coordinator be responsible for newly admitted children receiving timely assessments, identifying specialty providers, and verifying that a service plan is in place, then give oversight responsibility back to the caseworker.

Asked about the impacts of the health care coordination pilot, one agency noted, "This program has helped us ensure that families have access to the services needed as quickly as possible without unnecessary barriers or duplication." Such an outcome is desirable in all areas of our work to benefit the health, safety, and well-being of children in foster care. If care coordination can have this impact in the area of health, it is well worth the effort and time to set up and incorporate within our agencies.

"Oversight and implementation of care coordination provided higher standards and accountability for those involved in the health care needs of children in our program. Duplication of services decreased, accurate healthy history and information was obtained and shared with all persons involved in the care of the child. Positive relationships were established and maintained with service providers, which improved communication and quality of services which resulted in improvement of services our children received."

*Kinship Family and Children's Services*



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### Informational Letter

<b>Transmittal:</b>	08-OCFS-INF-02
<b>To:</b>	Commissioners of Social Services Executive Directors of Voluntary Authorized Agencies OCFS Facility Directors
<b>Issuing Division/Office:</b>	Strategic Planning and Policy Development
<b>Date:</b>	February 13, 2008
<b>Subject:</b>	The Use of Psychiatric Medications for Children and Youth in Placement; Authority to Consent to Medical Care
<b>Suggested Distribution:</b>	Directors of Social Services Planning Coordinators Health Care Coordinators Medical Directors of Voluntary Authorized Agencies Program Directors of Voluntary Authorized Agencies DJJOY Facility Health Staff
<b>Contact Person(s):</b>	See page 10
<b>Attachments:</b>	Yes
<b>Attachment Available Online:</b>	<a href="http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp">http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp</a>

#### Filing References, if applicable

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		18 NYCRR 441.15 18 NYCRR 441.17(g) 18 NYCRR 441.22	SSL 383-b FCA 355.4 NY Penal Law 70.20(4)(b)&(c) MHL 81 MHL 33.21(e) PHL 2504.1	Working Together: Health Services for Children in Foster Care	See References list

## **I. Purpose**

The purpose of this Informational Letter is to provide guidance on the safe and appropriate use of psychiatric medications for children and youth in the custody of OCFS, local social services district commissioners or voluntary agencies who have been placed in an out-of-home setting. The guidance presented is consistent with current research and professional publications that address psychiatric medication and children. For further information, a list of references is included in this document.

This Informational Letter also provides information on the authority to provide routine and informed consent for medical care of children in placement.

## **II. Background**

Children in care often have biological, psychological, and social risk factors that predispose them to emotional and behavioral disturbances. These may include a family history of mental illness, in utero exposure to alcohol or drugs, medical illnesses, a history of abuse and neglect, disrupted attachments, and exposure to violence in the home or community. Additionally, the stress experienced by families as they address the child's mental illness may be a contributing factor to the child's placement in care. For many of these children, medication has been identified as an integral component of a comprehensive mental health treatment plan.

*Psychiatric Medications*, also called psychotropic, psychoactive or behavioral medications, are chemical substances that act primarily upon the central nervous system where they alter brain function, resulting in temporary changes in perception, mood, consciousness and/or behavior. They are used to treat the symptoms associated with mental health disorders such as attention deficit-hyperactivity disorder (ADHD), psychosis, depression, and anxiety.

The advent of symptom-targeted medications for mental illness has had a significant impact on patients, physicians, medical practice and society. Physicians have tools for treatment that are effective, enabling some individuals with debilitating symptoms to function in the community. Additionally, the stigma of mental illness has decreased. Since the introduction of lithium in the 1940's, the pharmaceutical industry has produced an array of psychiatric medications. The availability of multiple medications that address specific symptoms allows prescribers considerable latitude in choosing a medication or combination of medications to produce the desired outcome while minimizing undesirable effects. But these practices also raise concerns about the impact of psychiatric medications on children's developing brains and bodies.

Scientifically controlled double-blind studies, the “gold standard” for research, have shown that psychiatric medications are generally safe and effective for adults. However, many psychiatric medications have not undergone clinical trials with children to prove their efficacy, safety, and long-term impact. The Food and Drug Administration (FDA) determines whether a medication is safe and effective prior to approving it for marketing. Though pharmaceutical companies cannot market medications for a use not indicated by the FDA, physicians may prescribe the medication for “off-label” use. “Off-label” refers to the use of drugs for patient populations or conditions other than those for which the FDA has “approved” them as “safe and effective.” This does not necessarily mean that these medications are not safe and effective for this population (Malkin, 2005). For these reasons, care must be taken in prescribing and administering psychiatric medications for children and youth, particularly in regard to “off-label” use of such medications.

### **III. Program Implications**

As part of their responsibility for the safety, permanency and well-being of children and youth placed in their care, OCFS facilities, local social services districts and authorized foster care agencies are advised to provide diligent and thoughtful oversight of medical care provided, particularly in regard to the use of psychiatric medications. A suggested framework for this oversight is provided below.

#### Assessment

Any child being considered for psychiatric medication must have thorough medical and mental health assessments. These are completed upon the child’s entry into care and at periodic intervals thereafter as set forth in 18 NYCRR 441.22.

The medical assessment is critical in that the symptoms attributed to mental illness may have a variety of causes. Conditions such as Fetal Alcohol Spectrum Disorder (FASD), lead poisoning, significant head trauma, premature birth, and substance abuse by the child may result in problems with executive functioning, cognition or emotional regulation. All medical conditions should be identified so that suitable interventions will be chosen by the medical practitioner and treatment team.

The central component of a mental health assessment is a clinical appointment with a qualified mental health practitioner. Refer to Chapter 1 of “Working Together: Health Services for Children in Foster Care” for a listing of the elements of the mental health assessment and those who would be considered qualified mental health professionals. This section is also attached herein and the entire manual is on the OCFS website.

([http://www.ocfs.state.ny.us/main/sppd/health\\_services/manual.asp](http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp))

The qualified mental health practitioner should be provided with the results of the medical assessment and a complete history of the child's functional status and behavior in various settings, such as the foster home or facility, school, day care center, and playground. If the child was taking psychiatric medication when he or she entered care, that prescription should be verified with the prescriber. Psychiatric medication should only be discontinued under the supervision of a medical practitioner, as side effects can result from the sudden cessation of some medications.

To accurately determine the impact of new medications, baseline functioning is best assessed by the administration of a pre- and post-symptom scale (e.g., Connors' Rating Scales for attention deficit hyperactivity disorder, Overt Aggression Scale for aggression, Children's Depression Inventory for depression). If this is not practical, it is recommended that the frequency and severity of target symptoms be quantified before and after the medication has been added. In addition to measurements of mental health symptoms, baseline information is also needed on the child's physical health status (e.g., weight, blood pressure, blood tests) to determine the impact of the medication.

### Diagnosis

The mental health assessment may result in a diagnosis with corresponding numerical codes from the multi-axial system outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). This system organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of the disorder or disability:

Axis I – clinical disorders, including major mental disorders, as well as developmental and learning disorders

Axis II – underlying pervasive or personality conditions, as well as mental retardation

Axis III – medical conditions which may be relevant to the understanding and treatment of the mental disorder

Axis IV – psychosocial and environmental factors contributing to the disorder

Axis V – Global Assessment of Functioning (GAF) on a scale of 100 to 0

A DSM diagnosis is a helpful starting point in understanding the child's behavior, mood, cognition, and adjustment. However, it may be difficult to formulate an accurate diagnosis of mental illness in children based on the DSM. Children may not fit the symptom criteria established for adults for certain disorders, such as bipolar. The developmental changes experienced by children as well as their malleability can make a stable diagnostic label hard to come by. Additionally, the trauma experienced by many children prior to placement as well as issues such as disrupted attachments, school problems, and substance abuse may result in a presentation which points erroneously toward mental illness.

**For these reasons, treatment of children with psychiatric medication should focus on the relief of undesirable symptoms** (Malkin, 2005). Accurate diagnosis can be a guide to treatment, but the effectiveness of the medication regimen is best determined by the alleviation of targeted symptoms with minimal undesirable side effects.

### Behavioral Planning

Many children and youth in out-of-home placements present behavioral challenges for their caregivers at some point. Assisting the child in adjusting to placement and managing emotions and behavior is integral to well-being. The mental health assessment is an important tool in identifying the child's strengths and past traumas, and a thorough assessment should include treatment recommendations that can be incorporated into a behavioral plan. This plan could include strategies such as a tiered reward system, play therapy, trauma work, sensory integration exercises, or recreational activities. The behavioral plan should be incorporated into the Family Assessment and Service Plan (FASP).

Psychiatric medication may be part of the plan. These medications may assist the child in managing strong emotions, such as rage, so that he or she is better able to benefit from a treatment like cognitive behavioral therapy. They may also help the child to concentrate in school, improve peer relationships, sleep better, and enjoy life. However, because the effects of psychiatric medications on any individual cannot be guaranteed, it is important to try a variety of alternative interventions before prescribing medication. Medication should not be the sole component in the behavioral plan.

After the child's behavior and mood become stable, it is recommended that the prescriber adjust the medication dosage to the minimum dose at which the medication remains effective and side effects are minimized. Attempts may also be made to discontinue the medication (Bellonci, 2006; Irwin, 2002), as the child may have benefited sufficiently from alternative interventions to function well without medication. This practice reinforces the development of coping, anger management and problem-solving skills, and builds the child's sense of control and self-reliance. It also assists in determining the soundness of initial diagnostic impressions. As diagnoses can have lasting consequences, it is important to determine if the child is accurately diagnosed with a mental illness that is alleviated with medication, or if the presenting problems can be explained and addressed in other ways.

### Communication Protocols

Clear communication protocols are important when a child is taking psychiatric medications. The decision to treat a child with psychiatric medications should be made in consultation with the parent or guardian and a team that should include the caseworker, caregivers, health care coordinator, agency staff with oversight responsibilities, pediatrician, and psychiatrist. The

team must carefully balance the risks of medication with the anticipated benefits.

Drug information sheets should be provided to caregivers and the parent or guardian as soon as reasonably possible. Caregivers will need detailed instructions on administering the medication. They also need to know what to expect from the medication and be alert for effects, both desirable and undesirable. Understanding the role that the medication plays in the overall treatment plan helps caregivers to comply with the regimen and monitoring requirements.

Agency policies should establish clear protocols for information sharing that include the following:

- The use of a Medication Administration Record (MAR);
- Dissemination of information to caregivers, team members and parent or guardian;
- Proactive policy for seeking and collecting information on the child's status from caregivers, school personnel, community programs, parent or guardian, and other parties that observe the child in various settings;
- Providing current information to persons administering medication outside the foster care setting (e.g., during home visits); and
- Discussion of medication during routine caseworker visits to foster homes.

#### General Authority to Consent to Medical Care

In accordance with New York State laws and regulations, any medical care for a child in placement must be provided pursuant to an authorized consent. Who may consent to medical care for a child in placement depends on how the child came into placement.

#### *Article 3 (Juvenile Delinquent) Placements*

Children may be placed under Article 3 of the Family Court Act (FCA) with a local social services district or with OCFS. Where a child is placed with a local social services commissioner, the regulations at 18 NYCRR 441.22(d) require the district to request authorization in writing from the child's parent or guardian for routine medical and psychological assessments, immunizations, medical treatment, and emergency medical or surgical care if the parent or guardian is unavailable when such care becomes necessary. This request must be made within 10 days after the child is taken into care. Absent consent, the local commissioner or authorized agency has no inherent authority to provide medical care. Accordingly, for those juvenile delinquents placed with a local commissioner where the parents or guardians do not consent to routine care, a court order providing appropriate authority should be sought.

Where children are placed under Article 3 of the FCA with OCFS, Section 355.4 of the FCA provides that OCFS has the authority to consent to routine medical, dental and mental health services and treatment. Thus, if a child is

adjudicated as a juvenile delinquent and placed with OCFS and OCFS then places the child with a voluntary authorized agency, OCFS would have the authority to consent to routine medical, dental and mental health services and treatment in the absence of the parent or guardian. The placement order permits administration of psychiatric medications only if such medication is part of an ongoing mental health plan that existed prior to placement with OCFS, unless the court order specifically provides otherwise.

*Article 7 (Person in Need of Supervision) Placements*

For children placed with a local social services commissioner under Article 7 of the FCA, the regulations at 18 NYCRR 441.22(d) require the district to request authorization in writing from the child's parent or guardian for routine medical and psychological assessments, immunizations, medical treatment, and emergency medical or surgical care if the parent or guardian is unavailable when such care becomes necessary. This request must be made within 10 days after the child is taken into care. Absent receipt of such consent, the local commissioner has no inherent authority to provide medical care, so a court order providing appropriate authority should be sought.

*Article 10 (Child Protective) Placements*

Where children are removed and/or placed with a local social services commissioner or voluntary authorized agency under Article 10 of the FCA, the regulations at 18 NYCRR 441.22(d) require the local commissioner or authorized agency to request authorization in writing from the child's parent or guardian for routine medical and psychological assessments, immunizations, medical treatment, and emergency medical or surgical care if the parent or guardian is unavailable when such care becomes necessary. Again, this request must be made within 10 days after the child is taken into care. If consent is not given, or pending receipt of such consent, where the child has been removed under Article 10 or placed by a court into the custody of the local commissioner of social services under Article 10, the local commissioner has the authority under Section 383-b of the Social Services Law (SSL) to give consent for medical, dental, health and hospital services for the child. Section 383-b clearly covers routine care and we understand it to also cover emergency care and non-routine care. However, it is still best to get parental consent if possible.

*Juvenile Offender Placements*

Where juvenile offenders are placed with OCFS under Section 70.20 of the Penal Law, the court is required to ask parents or guardians to consent to routine medical, dental and mental health services and treatment. If the parents or guardians do not consent, the commitment order is deemed to give OCFS consent for routine medical, dental and mental health services and treatment. The placement order permits administration of psychiatric medications only if such medication is part of an ongoing mental health plan that existed prior to placement with OCFS, unless the court order specifically provides otherwise.

*Voluntary Placements*

Where a child is placed through a voluntary placement under Section 384-a of the SSL, the placement is under such terms as are agreed to by the parties. If the placement agreement specifies terms on consent to medical care, those terms will govern. If the issue is not addressed in the agreement, the local social services district or voluntary authorized agency has no authority to consent to any sort of medical care. The best practice in voluntary placements is to be certain the issue of consents for medical care is addressed in the placement agreement.

*Surrender of Parental Rights*

Where there has been a surrender of parental rights under Section 383-c or 384 of the SSL, the surrender ends the parental rights of the biological parent and the biological parent has no authority to consent to any form of medical care for the child, including the administration of psychiatric medications. If both parents have surrendered their parental rights, then the local commissioner or authorized agency having guardianship of the child has full authority to consent to any medical care or procedure.

*Termination of Parental Rights*

Similarly, where that has been a termination of parental rights under Section 384-b of the SSL, the termination ends the parental rights of the biological parent and the biological parent has no authority to consent to any form of medical care for the child, including the administration of psychiatric medications. If the rights of both parents have been terminated, then the local commissioner or authorized agency having guardianship of the child has full authority to consent to any medical care or procedure.

Informed Consent and Capacity to Consent to the Administration of Psychiatric Medications

The authority to consent to medical care described above generally applies to routine medical care. However, for certain types of medical care or treatments, including the administration of psychiatric medications, medical practitioners will usually require informed consent. Having the authority to consent to routine medical care will not necessarily authorize OCFS, the local commissioner or the authorized agency having custody of a child to also give informed consent, as informed consent will generally be sought by medical practitioners only for non-routine care or treatments.

Informed consent requires that the person giving consent:

- (1) be told details of the proposed care or treatment, such as the duration and the procedures to be followed;
- (2) have the opportunity to ask questions about the proposed care or treatment; and
- (3) have the risks, benefits and alternatives to the proposed care or treatment clearly explained to them.

Informed consent means that the person giving consent has been provided comprehensive information on the medication and understands the risks, benefits, and alternatives of treatment. Information should be offered in a language and terminology understood by the consentor. The person being asked to provide informed consent should be provided with written information as well as an opportunity to ask questions. Refer to Chapter 6 of “Working Together” for additional considerations. This section is also attached herein.

This leads to the question of who may issue informed consent and under what circumstances. As a general rule, prior to the administration of psychiatric medication to children in placement, informed consent must be requested from the parent or guardian. However, there are two exceptions to this general rule.

1. Pursuant to Section 2504 of the Public Health Law, a person who is 18 years of age or older, is married or is the parent of a child may give consent, including informed consent, to any medical care and treatment, including the administration of psychiatric medications. No one else is authorized to consent for care in this case unless the court has determined that the individual is incapacitated and appointed a guardian or has otherwise intervened to authorize this type of medical care.

2. If the parental rights of both parents have been surrendered or terminated, only the commissioner or authorized agency with guardianship, or the court, can give informed consent to this type of medical care. (Please note that references hereafter to obtaining the consent of the parent or guardian are inapplicable to situations where the parental rights of both parents or a guardian other than the commissioner or an authorized agency have been surrendered or terminated.)

Outside of those two situations, OCFS recommends that informed consent be first sought from the parent or guardian.

If the parent or guardian objects to the medication, OCFS, the social services district or authorized agency should:

- work with them to understand the basis of the objection,
- pursue any reasonable treatment options that the parent or guardian suggests,
- provide the parent or guardian an opportunity to meet with the prescriber and treatment team, and
- assist the parent or guardian in obtaining a second opinion, if requested.

If the parent or guardian and the treatment team cannot agree on the use of psychiatric medication, the OCFS facility, local district or authorized agency should seek legal counsel to determine if court intervention is advisable.

If the parent or guardian is unavailable or the parent or guardian does not respond to repeated requests to provide informed consent, consent may be provided in accordance with the legal placement authority.

- If the child is placed pursuant to an order or adjudication under Article 10 (child protective) of the FCA, the social services commissioner or his or her designee can provide consent.
- If the child is placed voluntarily or pursuant to FCA Article 7 (PINS), a court order must be sought to authorize the medication.
- If a youth is placed pursuant to FCA Article 3 (juvenile delinquent) in the custody of a local social services district, a court order must be sought to authorize the medication.
- If the youth is placed pursuant to FCA Article 3 in the custody of OCFS and psychiatric medications were part of an existing health care plan at the time the youth was admitted to OCFS custody, the placement order authorizes OCFS to continue the existing course of treatment without additional consent. The introduction of new psychiatric medications would require a court order.
- If a youth is placed pursuant to Penal Law 70.20 (youthful offender), a court order must be sought to authorize the medication.
- If a child is placed pursuant to a surrender or termination of parental rights, the social services commissioner or authorized agency with guardianship of the child provides consent. Parental consent is not sought.

The commissioner or designee and the court if applicable must also receive information on the medication in order to provide an informed consent.

Additionally, there are provisions in Section 33.21(e)(2) of the Mental Hygiene Law that empower a minor 16 years of age or older residing in a psychiatric hospital to consent to the administration of psychiatric medication if:

- The minor has the capacity to consent, and
- A physician determines that the medication is in the minor's best interest, and
- The parent or guardian is not available or refuses to give consent, and a psychiatrist agrees with the first physician that the child has capacity to consent and that the medication is in the minor's best interest; or requiring the consent of the parent or guardian would have a detrimental effect on the minor, and a psychiatrist agrees with the first physician that the child has capacity to consent, that the medication is in the minor's best interest, and that requiring consent of the parent or guardian would have a detrimental effect.

In cases where the parent or guardian is refusing to consent to the administration of psychiatric medication or has not made him or herself available for purposes of providing consent, the medical professional should evaluate whether the refusal or failure to be available creates reasonable cause to suspect child maltreatment for failing to provide adequate medical care and

should make a report to the Statewide Central Register of Child Abuse and Maltreatment, if appropriate.

### Assent

In addition to informed consent from the parent or guardian, the assent of the child should be sought for psychiatric medications. The child needs to understand, in accordance with his or her developmental status, how the medication may impact the way he or she feels, acts, and thinks, and the benefits and risks. Older youth may be concerned about side effects such as weight gain, or being labeled with a diagnosis of mental illness. If the treatment team, caregivers, and parent or guardian have communicated well and agreed on the course of treatment, the child will receive consistent support in complying with the plan.

Where a child has the authority to give informed consent but the child does not wish to take the medication, we recommend spending some time talking with the child to understand and address his or her concerns. It may be helpful for a foster parent, caseworker, or facility staff to accompany the child to an appointment with the prescriber to help the child better understand the recommendation for medication and the risks to the child if the child does not take the medication.

When the child's condition or actions present a serious and immediate threat to personal safety, it may be necessary to administer a psychiatric medication over the child's objection on the advice of medical professionals. These circumstances should be addressed in agency policies and procedures.

### Prescribing Psychiatric Medications

Ideally, psychiatric medications are prescribed by a psychiatrist (preferably specializing in child and adolescent psychiatry), psychiatric nurse practitioner, or developmental pediatrician. Given the shortage of these practitioners, medication may be prescribed by the medical home (primary care) physician if recommended as a result of the mental health assessment. The use of a psychiatrist consultant can enhance the medical home physician's ability to manage psychiatric medication regimens.

In identifying clinicians in the community to treat children in placement, we recommend seeking out those who follow the recommended prescribing principles below. If the prescriber diverges from these practices, discuss the rationale for the medication therapy with the prescriber, and request that this rationale be documented. The following list of recommended prescribing principles has been developed to assist social services districts, authorized agencies and OCFS facilities in their oversight and monitoring of psychiatric medications prescribed for children in care. ***It is not intended to dictate treatment decisions by clinicians.***

Recommended principles for prescribing psychiatric medications for children are as follows:

- Individualize medication decisions for each child.
- Identify the symptoms targeted by the medication.
- Consider the balance between benefits and risks.
- Choose medications in this order of preference, as appropriate:
  - 1) FDA approved for psychiatric use in children;
  - 2) Approved for the presenting symptoms or diagnosis in adults with evidence of effectiveness and safety in children;
  - 3) Approved in children for a different usage but with evidence of effectiveness and safety in children.
- Medications with more data regarding safety and efficacy are preferred over those new to the market.
- “Start low and go slow”; i.e., begin with low dosages and increase slowly.
- Allow sufficient time for the effects to be seen before increasing the dosage or determining that the medication is ineffective.
- Make only one change at a time; e.g., change a dosage or add a different medication.
- If a medication does not result in the desired effect, adjust the dosage or discontinue the medication (this must be done gradually for some medications).
- If side effects of the medication are not tolerable, try a different medication rather than adding a medication to counter the side effects.
- After the child has been stable for a period of time, medication dosages should be adjusted by the prescriber to the minimum dose at which a medication remains effective and side effects are minimized. Attempts may be made at the prescriber’s discretion to discontinue the medication to determine if it is still needed.
- Explain to the child, in a developmentally appropriate manner, what to expect from the medication.

*References for above list: (Bellonci, 2006; Arizona, 2006; Irwin, 2002; NYS OMH, 2004)*

### Monitoring

Periodic monitoring by the prescriber is necessary for all children taking psychiatric medications. Recommended monitoring includes the following:

- Clinical assessment for treatment effect;
- Clinical assessment for side effects (may include height, weight, blood pressure, involuntary movements, electrocardiogram);
- Laboratory tests as indicated for specific medication;
- Review of observations from the child, caregivers and treatment team on the effects of the medication;
- Objective evaluation of targeted symptoms, such as repeating symptom inventories or scales that were performed prior to initiation of medication; and

- Immediate communication with the child, caregivers and treatment team on recommended changes in the current medication regimen.

The frequency of medication monitoring appointments will vary depending on the medications involved and the child's condition. For example, monitoring may be needed as often as weekly if the child is unstable or many medications are involved. The medication manufacturer may recommend a monitoring schedule. If the agency has specific requirements for the frequency of psychiatric medication monitoring, these must be communicated to the prescriber, the caregivers, the treatment team and the child to support compliance.

#### Indicators for Independent Review

It is beneficial for districts and agencies to develop the capacity for a high-level review or second opinion by a medical expert of the medication regimen for children in placement. Circumstances that may warrant an independent review include but are not limited to the following:

- Child prescribed more than three psychiatric medications (Bellonci, 2006);
- Child prescribed more than one psychiatric medication from the same class of medications (e.g., two anti-psychotics) (Bellonci, 2006);
- Psychiatric medication prescribed for a child younger than 5 years of age (Coyle, 2000; Rey, 2000);
- Medications needed to manage target symptoms are causing significant side effects (e.g., dramatic weight gain, sleep disturbance) (Irwin, 2002; Irwin, 2004); and
- Prescribing practices vary significantly from those recommended above.

In these cases, it is recommended that the prescriber document an explanation for the recommended course of treatment and that an independent reviewer examine the mental health assessment, the presenting symptoms and behaviors, the rationale for the medications prescribed, the status of non-medication interventions, and previous medication trials. The risks of the medication regimen must be balanced against the benefits to the child in his or her unique circumstances. Long-term effects should be considered as well as immediate concerns.

#### Quality Assurance

A quality assurance plan is recommended to monitor the use of psychiatric medications in the out-of-home population. Agencies and districts are encouraged to develop a plan to obtain aggregate data on the use of psychiatric medications for children in their care; identify and use mental health professionals that implement the practices recommended above; and routinely review samplings of individual records. Any concerns should be addressed through a process of continuous quality improvement.

Individual record reviews should address the following questions:

- Did the child receive a comprehensive medical and mental health assessment prior to the initiation of medication?
- Have appropriate consents been obtained?
- Is there adequate communication about medication among all parties, including the child and parent or guardian?
- Has a multi-faceted behavioral plan been developed, documented and implemented?
- Are recommended prescribing and monitoring practices followed?
- Have independent reviews been conducted when indicated?
- Does documentation include the rationale for the medication regimen?
- Are clinical and laboratory monitoring reports documented, and resulting concerns addressed?

#### IV. Contact Persons

Questions concerning this Informational Letter may be directed to:

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*/s/ Nancy W. Martinez*

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## ATTACHMENT

### *Working Together* HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

#### Initial Mental Health Assessment

The initial mental health assessment must be conducted for children age 3 and older. It is recommended that this be completed within 30 days of placement. Although not explicitly required in NYS OCFS regulations, EPSDT [federal Early Periodic Screening, Diagnosis and Treatment standards] requires an assessment of mental health development for all Medicaid eligible children,<sup>14</sup> and regulations specify that psychiatric and psychological services must be made available appropriate to the needs of children in foster care.<sup>15</sup>

The assessment includes (1) a mental health assessment conducted by a qualified mental health professional; (2) development of a mental health needs list; (3) list of child's strengths; and (4) development of a mental health treatment plan.

#### Health Care Coordination Activities

Before the mental health assessment takes place, you can help further the process by gathering records on the child's past mental health issues, diagnoses, and treatment, if any. After the assessment is completed, you will be involved in supporting the child's mental health treatment plan, including working with the child's caregivers, birth parents, and service providers.

Practitioners providing the assessment may include:

Physicians experienced in providing mental health services:

- Developmental/behavioral pediatricians for children under age 5.
- Child and adolescent psychiatrists or general psychiatrists with experience in the care of children and adolescents.

Licensed clinical psychologists with training and/or experience with emotional problems of children and adolescents.

Nurse practitioners with certification in child and adolescent psychiatry.

Certified psychiatric clinical nurse specialists.

Certified social workers (CSWs) or Masters of Social Work (MSWs) with training and/or experience with the emotional problems of children and adolescents.

#### Components of Mental Health Assessment

The purpose of the mental health assessment is to obtain a complete picture of the child who has just been placed in foster care and to identify any emotional and behavioral needs, issues, or problems or risk thereof arising from the child's situation. Removal from the home, a history of

<sup>13</sup> 18 NYCRR 441.22(c)(2)(vii).

<sup>14</sup> EPSDT 5123.2A.

<sup>15</sup> 18 NYCRR 441.15.

abuse or neglect, separation from parents and siblings, changing schools, and changing foster homes are examples of stressors.

The practitioner derives this picture by obtaining the child's history, interviewing the child, caregivers, and birth parents and completing the following assessment components. It may take more than one interview to obtain the needed information and arrive at a diagnosis. Children are often traumatized by being removed from their homes and need time to adjust to their new situation.

1. Mental health/psychiatric history – obtained by interviewing the child, family, and caregivers, covering the following information:
  - Identifying information
  - Past psychiatric history
  - Past and current psychiatric medications
  - Identification of individual strengths/assets
  - Identification of individual deficits/liabilities
  - Developmental history
  - School history
  - Family history
  - Social and behavioral history
  - Medical history (including results of initial medical assessment)
  - Drug/alcohol history
  - Trauma and abuse history
2. Mental status examination – accomplished by interviewing the child and examining the child's appearance, behavior, feeling (affect and mood), perception, thinking, and orientation to time, place, and person.
3. Assess the circumstances of placement, family life events, and traumatic events, and observe for signs and symptoms:
  - Risks for suicide, self-mutilating behaviors, and/or violence
  - Substance exposure, misuse, abuse, and addiction
  - Maltreatment, including physical, sexual, emotional abuse and neglect
  - Risk of placement disruption
  - Risky sexual behavior
  - Risk of antisocial behavior
4. If clinically indicated, completion of diagnostic screening and assessment tools (behavior, mood, etc.) (*see section 7, Resources, for a list of assessment tools*).
5. If clinically indicated, psychological testing
6. Development of a mental health needs list or diagnosis (*see Chapter 2, Preventive and Ongoing Health Care, for information on the DSM-IV-TR Manual*).
7. Mental health treatment plan for the child's identified needs, consisting of treatment goals; treatment objectives; and treatment methods/interventions/services (types, frequency, specific providers).

## Guidance for Caregivers

You have an important role in helping foster parents or childcare staff understand the mental health needs of the child placed in their care. If mental health information is available at the time of placement, discuss it with the caregivers so that they can be more aware of the child's needs. As the child becomes more comfortable in the placement setting, he or she may begin to exhibit certain different behaviors. This is a critical time to support caregivers and provide practical guidance and training to address these changes. Caregivers should be aware of this possibility, make note of the child's behavior, and pass the information on to the person conducting the mental health assessment. It is important to realize that the child may be reacting to feelings of separation, loss, or rejection, and his or her behavior may be more a reflection of the situation than an indicator of a genuine mental illness.

Some of the behaviors that caregivers should be alert to are:

- Angry outbursts.
- Excessive sadness and crying.
- Withdrawal.
- Lying or stealing.
- Defiance.
- Unusual eating habits, such as hoarding food or loss of appetite.
- Sleep disturbances.
- Sexual acting out, such as seductive behaviors toward caregivers.
- Change in behavior at school, including truancy.

Please note that if the child appears to be in crisis, immediate referral to a mental health provider should be made. If a foster parent identifies a child in crisis, he/she should contact the caseworker immediately.

## Informed Consent for Non-Routine Health Care

Even if consent for routine evaluation and treatment has been obtained, medical providers will generally look for a higher level of consent – known as “informed consent” – for non-routine or elective medical or mental health care not generally provided as part of primary health care. Local districts that have obtained consents from a parent or guardian should evaluate the scope of such consent to determine whether it addresses both routine and non-routine medical care and treatment. For procedures or interventions that are not emergency in nature but call for informed consent, the health care provider should always contact the caseworker or the health care coordination staff at the agency. It is then the agency’s responsibility to facilitate the consent process.

Informed consent is required for:

Any hospitalization.

Dispensing of any psychiatric medication (*see Chapter 5, Medication Administration and Management*).

Any procedure that requires anesthesia.

Any surgery.

Any invasive diagnostic procedure or treatment.

“Informed consent” implies that the person giving consent has had the opportunity to ask questions, understands the risks, benefits, and alternatives of the treatment, and has been informed of the following types of information:

Diagnosis and symptoms being treated.

How the procedure/therapy fits with the treatment plan.

Nature of the procedure/treatment.

Benefits, risks, and side effects.

Projected course and duration of therapy.

Alternative approaches to treatment.

Assurance of monitoring for complications and side effects.

How to contact the clinical provider of the proposed procedure/treatment.

Location where the procedure/treatment will be performed.

Necessity, type, and risks of anesthesia, if any.

Proposed length of hospitalization, if any.

It is best to give this type of information to the person (birth parent or guardian, adolescent) orally and to be available to answer questions. If requested, follow up the discussion with information in writing.

If the birth parent or guardian objects to signing the consent, take the following steps:

- Set up a meeting with the practitioner to educate the parent.
- Obtain a second opinion, if requested.
- Pursue any reasonable treatment options that the parent may suggest.



**George E. Pataki**  
Governor

**NEW YORK STATE**  
**OFFICE OF CHILDREN & FAMILY SERVICES**  
52 WASHINGTON STREET  
RENSELAER, NY 12144

**John A. Johnson**  
Commissioner

## Informational Letter

<b>Transmittal:</b>	04-OCFS-INF-05
<b>To:</b>	Local District Commissioners Executive Directors of Voluntary Agencies
<b>Issuing Division/Office:</b>	Strategic Planning and Policy Development
<b>Date:</b>	June 18, 2004
<b>Subject:</b>	Smoking in Foster Homes
<b>Suggested Distribution:</b>	Directors of Services Foster Boarding Home-Finding Staff
<b>Contact Person(s):</b>	See Page 3
<b>Attachments:</b>	none
<b>Attachment Available On – Line:</b>	N/A

### Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		Part 443		NYS Foster Parent Manual	

### I. Purpose

The purpose of this Informational Letter is to recommend that local social services districts and voluntary agencies with foster boarding home programs review their current policy and practices concerning foster parents and foster children and the smoking of tobacco, if such a review has not been undertaken in the last few years. This review is recommended to support the good health of foster children residing in foster homes and to take necessary steps to avoid the dangers caused by a child smoking tobacco or being exposed to second-hand smoke.

### II. Background

In Chapter 5, “Daily Life” of the NYS Foster Parent Manual (dated September 2002), there is a short section entitled “Smoking.” The following is stated therein:

“Foster parents have the right to forbid or allow smoking in their own home, but given the known health risks, they should discourage foster children from starting or continuing smoking. Foster parents should not purchase tobacco products for any foster child, and it is illegal in New York State for children under 18 to purchase cigarettes.”

“Foster parents who smoke should do so in an area where foster children are not subjected to second-hand smoke. Smoking should never be allowed in the foster child’s sleeping area.”

Since then, the New York State Health Department has issued an on-line publication entitled, “Second-hand Smoke – It Takes Your Breath Away.” For your information, the link to the publication is

<http://www.health.state.ny.us/nysdoh/smoking/second/second.htm>.

The publication indicates that:

“Each year, an estimated 3000 American non-smokers die from lung cancer caused by second-hand smoke.”

A paragraph pertaining to children states:

“While second-hand smoke is dangerous for nonsmoking adults, it is even more dangerous for babies and children whose lungs are still developing. Infants and young children of parents who smoke are more likely to have lower respiratory tract infections, such as pneumonia and bronchitis. They are more likely to suffer from middle ear infections, sore throats and colds. And, second-hand smoke can cause youngsters with asthma or allergies to have longer and more severe attacks.”

### **III. Program Implications**

There is extensive information that points to the danger associated with smoking and second-hand smoke, particularly concerning infants, young children and children with asthma and other allergies. As such, it is suggested that local districts and voluntary agencies with foster boarding home programs review their policies and practices pertaining to smoking, if such a review has not been undertaken in the last few years.

Case planners and foster parents should actively discourage foster children from smoking or continuing to smoke. They must not assist the foster child in purchasing or obtaining cigarettes. It is illegal for a child under 18 to purchase cigarettes. In a relationship between a foster parent or a case planner with an older foster child, there are numerous matters to attend to in terms of supporting the youth’s optimal development, promoting a desired permanency outcome and promoting independent living skills. It is not suggested that attention to smoking prevention necessarily be a top priority for the foster parent or the case planner. However, given the known health risks associated with smoking, it would be appropriate to attempt to educate the foster child about the potential negative health impact of smoking. Additionally, foster parents are on firm ground in preventing a foster child from smoking in their home.

In suggesting that counties and agencies review their policies as they pertain to foster parents smoking, please understand that it is not recommended that you establish any steps that are likely to reduce your

cadre of foster parents to an insufficient level to meet your projected need for foster homes. An alternative to establishing absolute restrictions may be to establish a policy wherein training and education are directed at both existing and new foster parents. Such training and education could spell out the risks associated with second-hand smoke, as described earlier in this Informational Letter and in the publications referenced earlier. In addition to outlining the risks associated with second-hand smoke, the following suggestions should be made to foster parents:

- attempt to limit smoking in their homes to the extent practicable
- in particular, avoid smoking where a foster child sleeps, eats and/or spends a lot of time
- avoid smoking in vehicles when transporting foster children
- be extra diligent in avoiding exposing young, allergenic and asthmatic children to second-hand smoke.

Given the known health risks, local districts and voluntary agencies should avoid placing very young, allergenic and asthmatic foster children in homes where one or more of the residents smoke. Where such a placement needs to occur because it is in the child's best interests or due to a lack of alternative foster homes, or happens inadvertently (i.e., it is learned after the placement that the child is allergenic or asthmatic) the local district or voluntary agency should especially educate the foster parents about the potential dangers to the child.

#### **IV. Contact Information**

Any questions concerning this Informational Letter should be directed to:

BRO – Linda Brown (716) 847-3145  
 User ID: [Linda.Brown@dfa.state.ny.us](mailto:Linda.Brown@dfa.state.ny.us)  
 RRO – Linda Kurtz (585) 238-8201  
 User ID: [Linda.Kurtz@dfa.state.ny.us](mailto:Linda.Kurtz@dfa.state.ny.us)  
 SRO – Jack Klump (315) 423-1200  
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 YRO – Pat Sheehy (914) 377-2080  
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 NYCRO -- Fred Levitan (212) 383-1788  
 User ID: [Fred.Levitan@dfa.state.ny.us](mailto:Fred.Levitan@dfa.state.ny.us)

*Nancy W. Martinez s/s*

---

#### **Issued By:**

Name: Nancy W. Martinez

Title: Director

Division/Office: Strategic Planning and Policy Development



**George E. Pataki**  
Governor

**NEW YORK STATE**  
**OFFICE OF CHILDREN & FAMILY SERVICES**  
52 WASHINGTON STREET  
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**John A. Johnson**  
Commissioner

## Local Commissioners Memorandum

<b>Transmittal:</b>	04-OCFS-LCM-04
<b>To:</b>	Local District Commissioners
<b>Issuing Division/Office:</b>	Strategic Planning and Policy Development
<b>Date:</b>	June 29, 2004
<b>Subject:</b>	Referrals of Young Children in Indicated CPS Cases to Early Intervention Services
<b>Contact Person(s):</b>	BRO – Linda Brown (716) 847-3145 User ID: <a href="mailto:Linda.Brown@dfa.state.ny.us">Linda.Brown@dfa.state.ny.us</a> RRO – Linda Kurtz (585) 238-8201 User ID: <a href="mailto:Linda.Kurtz@dfa.state.ny.us">Linda.Kurtz@dfa.state.ny.us</a> SRO – Jack Klump (315) 423-1200 User ID: <a href="mailto:Jack.Klump@dfa.state.ny.us">Jack.Klump@dfa.state.ny.us</a> ARO – Bill McLaughlin (518) 486-7078 User ID: <a href="mailto:William.McLaughlin@dfa.state.ny.us">William.McLaughlin@dfa.state.ny.us</a> YRO – Pat Sheehy (914) 377-2080 User ID: <a href="mailto:Patricia.Sheehy@dfa.state.ny.us">Patricia.Sheehy@dfa.state.ny.us</a> NYCRO -- Fred Levitan (212) 383-1788 User ID: <a href="mailto:Fred.Levitan@dfa.state.ny.us">Fred.Levitan@dfa.state.ny.us</a>
<b>Attachments:</b>	See links <a href="http://www.einy.org/policy.html">http://www.einy.org/policy.html</a> <a href="http://www.einy.org/directory.html">http://www.einy.org/directory.html</a>
<b>Attachment Available On – Line:</b>	yes

### I. Purpose

The purpose of this Local Commissioners Memorandum (LCM) is to establish standards and procedures for referring a child under the age of three to early intervention services when the child is the subject of an indicated report of child abuse or maltreatment.

## II. Background

Recent revisions to the federal Child Abuse Prevention and Treatment Act require states to establish standards and procedures for referral of young children to early intervention services. Article 25, Title II-A, of the Public Health Law establishes the Early Intervention Program in New York State and makes the New York State Department of Health the lead agency for the program. The Early Intervention Program is a voluntary program that identifies infants and toddlers with disabling conditions; evaluates their needs for a range of early intervention services; and develops individualized family service plans to address such needs. The Early Intervention Program offers a variety of therapeutic support services to eligible infants and toddlers with disabilities, and their families. Each of the 57 counties and New York City offer Early Intervention services.

On December 11, 2003 the Office of Children and Family Services issued 03-OCFS-LCM-25, *Protocol on Children in Foster Care Who Participate in the Early Intervention Program*, which provides additional information about the state's Early Intervention Program, as well as how to access services for foster children. This LCM links readers to <http://www.einy.org/policy.html>, the section of the website for the New York Association of Counties that includes policies for the Early Intervention Program. A directory of the Department of Health's regional office contacts and of county Departments of Health can be found at this link, <http://www.einy.org/directory.html>.

A growing body of evidence suggests that children involved in tumultuous or neglectful family situations may experience developmental delays. The impacts on young children often manifested themselves in later attachment disorders; behavioral problems; and social, emotional, motor and cognitive delays. The Early Intervention Program offers screening and services as necessary and appropriate.

## III. Program Implications

Section 424(13) of the Social Services Law requires that each child protective service coordinate, provide, arrange, and monitor rehabilitative services for children and families. Accordingly, local social services districts must inform parents of children under the age of three who are subjects in an indicated report of child abuse or maltreatment of the Early Intervention Program, and refer them to the county's Early Intervention Program. A directory of lead agencies in each county may be found at the website cited above, under "Early Intervention County Connections." Direct contacts with this resource in the county will assist parents in accessing needed services.

*Nancy W. Martinez s/s*

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**Issued By:**

Name: Nancy W. Martinez

Title: Director

Division/Office: Strategic Planning and Policy Development

**TO:** Local District Commissioners, Medicaid Directors, Services Directors

**FROM:** Mark Kissinger, Deputy Commissioner  
NYS Department of Health, Office of Long Term Care

**SUBJECT:** Bridges to Health Waivers (B2H) for Children in Foster Care

**EFFECTIVE DATE:** January 01, 2008

**CONTACT PERSONS:** Department of Health: Priscilla Smith (518)486-6562  
Office of Children and Family Services:  
Mimi Weber 518-408-4064

The purpose of this GIS is to inform Local Social Service Districts (LDSS) that the New York State Department of Health (DOH) and the Office of Children and Family Services (OCFS) are authorized by the federal Centers for Medicaid and Medicare Services to implement a new Medicaid program, "Bridges to Health" (B2H) for children in foster care up to 21 years of age, beginning January 1, 2008.

B2H will provide community based services to children who are in the care and custody of a LDSS or OCFS and who have significant mental health care needs, developmental disabilities or medical fragility and who require an institutional level of care.

Administered as three separate targeted 1915(c) Medicaid waivers, the program will be phased in over a three year period, with a total 3,305 participant slots distributed between the three waivers by 2010: 2,688 serious emotional disturbance (B2H/SED); 541 developmentally disabled (B2H/DD); 76 slots medically fragile (B2H/MedF).

The services listed below will be available to participants in each waiver. Detailed descriptions can be found in the B2H Program Manual that is available on the OCFS website at <http://www.ocfs.state.ny.us/main/b2h>.

- Health Care Integration
- Skill building
- Family care giver supports and services
- Day habilitation
- Prevocational services
- Supported employment
- Planned respite
- Special needs community advocacy and support
- Crisis avoidance, management and training
- Immediate crisis response services
- Intensive in-home supports crisis respite
- Accessibility modifications
- Adaptive and assistive equipment

Initially, children must be in foster care and categorically eligible for Medicaid to be considered for enrollment in the B2H waivers. B2H participants who are discharged from foster care may remain in the B2H waiver if they meet the waiver and Medicaid eligibility criteria. A B2H participant who has been discharged from foster care will have her/his Medicaid eligibility determined based on a household of one, and her/his own income and resources will be compared to the Medically Needy level. If a child's income and/or resources exceed the Medically Needy level, s/he may spenddown. Either ADC-related budgeting or SSI-related budgeting may be used, whichever is most beneficial to the child. However, if SSI-related budgeting is used, a disability review must be completed. Medicaid and waiver eligibility must be renewed annually.

The LDSS will approve children for a B2H waiver based on their qualifying diagnosis. Each B2H waiver will be identified by separate restriction/exception (R/E) codes: • SED - R/E code 72; • DD - R/E code 73; • MedF - R/E code 74. Districts must enter the appropriate R/E code for each B2H participant as Medicaid claim payments will be made only for those with appropriately assigned codes. Training for specific claim procedures will be scheduled upon provider request.

The three year phase-in plan is designed to permit steady development of the needed administrative and service infrastructure for the waiver program, including the Health Care Integration Agencies (HCIA) and Waiver Service Provider (WSP) networks. The HCIA's are voluntary child care agencies responsible for the operational and administrative functions of the B2H waivers. The WSP networks will operate throughout the State to ensure the delivery of comparable B2H services—regardless of the location of a child's residence. Details regarding the phase-in plan, and other information regarding the program, are posted on the OCFS website at the above mentioned address.

The existing OCFS regions form the basis for the B2H regional designations. The B2H and OCFS regional designations are identical, with one exception: OCFS Region V is divided into the Lower Hudson Valley and Long Island B2H regions. Please refer to the website above for specific information regarding the OCFS and B2H regions.

An Administrative Directive (ADM) will be forthcoming with more detailed instructions regarding implementation and administration of the B2H program. OCFS will notify LDSS staff of upcoming training on administering the B2H program through the Statewide Training Automated Registration System (STARS). Topics will include B2H eligibility determination, data system entry and program monitoring. In addition, detailed information regarding the B2H program, including the phase-in plan, B2H eligibility determination rules and billing instructions, can be found in the B2H Program Manual posted on the OCFS website at the above mentioned address.

**TO:** All Local District Commissioners, Medicaid Directors, Service Directors

**FROM:** Betty Rice, Director  
Division of Consumer and Local District Relations

**SUBJECT:** Categorical Eligibility for Children in Foster Care

**EFFECTIVE DATE:** Immediately

**CONTACT PERSON:** Medicaid - Local District Liaison  
Upstate (518)474-8887 NYC (212)417-4500

The purpose of this GIS is to inform local departments of social services (LDSS) of Medicaid categorical eligibility for both Title IV-E and Non Title IV-E children in foster care. In the past, children in foster care who met the eligibility criteria under Title IV-E of the Social Security Act were deemed eligible for Medicaid, while those who did not meet the Title IV-E eligibility criteria, and those awaiting Title IV-E determination, had their Medicaid eligibility determined separately using a specific budgeting methodology for non Title IV-E children in foster care.

The Department submitted a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to provide Medicaid categorical eligibility for children who are in foster care. CMS has approved the State Plan Amendment. This change in policy is effective immediately, retroactive to January 1, 2005. Children in foster care identified as eligible for Medicaid with a spenddown, or who were either denied Medicaid or on Child Health Plus B due to excess income during the retroactive period, are now categorically eligible for Medicaid, if they are citizens or meet satisfactory immigration status. Changes to these cases should be made as they are identified by either Services staff or Medicaid staff or at next recertification, whichever comes first.

Therefore, all children who are in the care and custody of the local district commissioner, and who are citizens or have satisfactory immigration status, are eligible for Medicaid. In addition, children adjudicated as juvenile delinquents pursuant to Article 3 of the Family Court Act and placed into the custody of the Office of Children and Family Services, pursuant to Section 353.3 of the Family Court Act, and who are citizens or have satisfactory immigration status, are eligible for Medicaid. Districts are no longer required to do an eligibility determination for non Title IV-E children in foster care.

Upstate Title IV-E cases will remain Case Type 13 and Upstate non Title IV-E cases will remain Case Type 20. The Upstate categorical code for children in foster care will remain 07 "Removed by Court Order".

New York City procedures for authorizing Medicaid on SERMA for children in foster care remain the same. There are no changes to categorical codes for children in foster care in New York City.

As is current policy, an infant born to a woman eligible for and receiving Medicaid on the date of a child's birth, including a pregnant woman in foster care, is eligible for Medicaid until the end of the month of the infant's first birthday.

An Administrative Directive will be forthcoming. If you have any questions, please contact your Local District Liaison.

# Working Together

## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

NYS Office of Children and Family Services

### Appendix C

## Selected Health-Related Regulations and Statues

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# Working Together

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*NYS Office of Children and Family Services*

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- CFR 42, Section 2.14 Confidentiality of Alcohol and Drug Abuse Patient Records – Minor patients ..... 95

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## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

*NYS Office of Children and Family Services*

**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.**

# *Working Together*

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.

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### 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.

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

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

- 508.0 Scope
- 508.1 Definitions
- 508.2 General policy
- 508.3 Identification of persons eligible for C/THP services
- 508.4 Informing persons eligible for C/THP services about C/THP
- 508.5 Provision of C/THP services
- 508.6 Identification of available providers
- 508.7 Agreements with providers
- 508.8 Standards and periodicity
- 508.9 Coordination with related programs
- 508.10 Forms and reports
- 508.11 Payment
- 508.12 Continuing care providers

#### **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.



2                    Td                    This visit may be eliminated if first doses of Td and  
                         TOPV\*\*                    TOPV are given at visit 1.

Two-month interval between visits.

3                    Td                    If visit 2 is eliminated, the interval between visits  
                         TOPV\*\*                    1 and 3 must be at least two months.

6- to 12-month interval between visits.

4                    Td                    Interval between doses 3 and 4 may be extended but  
                         TOPV\*\*                    not shortened.

10-year interval between visits.

5                    Td                    Repeat every 10 years.

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\* FOOTNOTE: Before rubella vaccine is administered to females past menarche, the patient and/or her parent/guardian must be asked if she is pregnant. Pregnant patients must not be given rubella vaccine. If the patient is not pregnant, the theoretical risks to a fetus and the importance of not becoming pregnant for three months following vaccination must be explained to the patient before the vaccine is administered.

\*\* FOOTNOTE: TOPV should not be routinely administered to persons 18 years of age and older. -----  
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(3) Simultaneous administration of vaccines. The simultaneous administration of TOPV and one of the following has been shown to be both safe and effective: MMR, MR, measles, rubella, mumps, DTP, Td. It is also possible to administer TOPV, MMR (or a product containing one or more of its component antigens), and either DTP or Td simultaneously (using different injection sites). This latter practice is warranted if there is doubt that the recipient will return for further doses of vaccine or if an older, seriously under-immunized child must be brought up-to-date quickly (e.g., at the time of school entry). The Hib vaccine can be provided any time between the ages of 24 months and six years.

(4) Interruption of immunization schedule. When a delay between doses does not interfere with final immunity and does not necessitate starting the series over again, regardless of the interval elapsed, the schedule may simply be resumed where it was left off.

(8) Laboratory and other diagnostic tests. If a particular test (e.g., lead screening) is not indicated for a specific age group (or any age group), but the child presents history or symptoms calling for the test's use, the test should be performed.

(i) Tuberculin screening. The assessment for tuberculin risk should be made at each visit, with skin tests performed at age 12-13 months, three years and at each age interval thereafter. A tuberculin test should be administered prior to immunizing a child against measles. If that is not possible, the tuberculin test should be administered simultaneously with the measles vaccine. A tuberculin test should be delayed at least six weeks after the administration of a measles vaccine. Where the child's histories indicate a higher risk of tuberculosis, the test should be administered more frequently.

(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.

# *Working Together*

HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

*NYS Office of Children and Family Services*

## *Appendix D*

# Protocol: Children in Foster Care Who Participate in the Early Intervention Program

# *Working Together*

HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

*NYS Office of Children and Family Services*

PROTOCOL  
CHILDREN IN FOSTER CARE WHO PARTICIPATE IN THE EARLY INTERVENTION PROGRAM

## **PROTOCOL**

# **CHILDREN IN FOSTER CARE WHO PARTICIPATE IN THE EARLY INTERVENTION PROGRAM**

This protocol was developed by NYS Department of Health Early Intervention Program in collaboration with NYS Office of Children and Family Services.

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## **PURPOSE**

Children ages birth through three years may be eligible for participation in the Early Intervention Program (EIP) because they are experiencing developmental delays or disabilities. Some of these children will be in foster care. The purpose of this Protocol is to describe the procedures and steps that staff in local early intervention programs and child welfare systems should follow to coordinate the services they provide to children who are in foster care and may also be eligible for the early intervention services. The Protocol follows a child from referral to the Early Intervention Program through discharge; explains the requirements of the early intervention system and the child welfare system; and, addresses when staff from both systems should coordinate, collaborate and share information.

## **DESCRIPTION OF THE EARLY INTERVENTION PROGRAM**

### **Background**

Article 25, Title II-A of the Public Health Law establishes the Early Intervention Program (EIP), a voluntary program offering a variety of therapeutic and support services to eligible infants and toddlers with disabilities and their families. In New York State, the Department of Health is the lead agency for the Early Intervention Program. The EIP is administered locally in each of the 57 counties and New York City. An Early Intervention Official/Designee (EIO/D) in each municipality is responsible for identifying eligible children residing within the municipality and ensuring that early intervention services contained in the family's individualized family service plan (IFSP) are delivered (see **Appendix A** for definitions of key words and phrases).

The statewide EIP offers therapeutic and support services to infants and toddlers with disabilities and their families. The following services can be included in the IFSP: assistive technology devices and services, family training and counseling, home visits, parent support groups, special instruction, speech-language pathology and audiology, occupational therapy, physical therapy, psychological services, service coordination, nursing services, nutritional services, social work services, vision services and transportation/related costs necessary to participate in early intervention services and health services. The EIP only provides health services necessary to enable a child to benefit from other early intervention services while the child is receiving these services.

### **Eligibility**

To be eligible for early intervention services a child must be under three years of age and have a disability or developmental delay.

A disability means a child has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay (e.g., Down syndrome, autism, cerebral palsy) (see **Appendix B** - Children's Eligibility Status Based on Diagnosed Conditions with High Probability of Developmental Delay).

A developmental delay means that a child has not attained developmental milestones expected for the child's chronological age adjusted for prematurity in one or more of the following areas of development: cognitive, physical (including vision and hearing), communication, social/emotional and adaptive.

A developmental delay for purposes of the EIP is a developmental delay that has been measured by qualified personnel using informed clinical opinion, appropriate diagnostic procedures and/or instruments and documented as:

- a twelve month delay in one functional area; or
- a 33% delay in one functional area or a 25% delay in two areas; or
- if appropriate standardized instruments are administered during the evaluation, a score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standard deviations below the mean in each of two functional areas.

### **Major Provisions of the Early Intervention Program**

Public Health Law which governs the EIP requires provision of:

- initial and ongoing service coordination services for eligible children and families;
- a multidisciplinary evaluation provided to determine eligibility, including an opportunity to engage in a family assessment process;
- an individualized family service plan (IFSP) for eligible children and their families;
- delivery of early intervention services in the IFSP that are provided at no cost to families; and,
- delivery of services in natural environments with typical age peers, to the maximum extent appropriate. Natural environments are settings that are natural or normal for the child's age peers who have no disability, including the home, a relative's home when care is delivered by the relative, child care setting, or other community setting in which children without disabilities participate.

A Governor-appointed State Early Intervention Coordinating Council (EICC) advises and assists the NYS Department of Health regarding policy and systems issues related to the EIP. Each municipality has a Local Early Intervention Coordinating Council (LEICC) to advise and assist with local implementation and quality improvement activities.

### **Brief Description of the Early Intervention Steps**

#### Referral to the EIP

Early Intervention Officials/Designees (EIO/D) are responsible for ensuring that infants and toddlers that are at risk are identified, screened and tracked for appropriate periodic development, using all available state, local and community resources to accomplish this objective.

Primary referral sources are responsible for identifying and referring infants and toddlers suspected of having a disability or at risk for a disability to the EIO or public health official, as designated by the municipality, unless the parent objects to the referral (see **Appendix C** for a listing of Required Early Intervention Primary Referral Sources). Under NYS Public Health Law, Department of Social Services staff are identified as a Primary Referral Source and are responsible for referring children under three years of age who they suspect of having or being at risk of a developmental delay (see **Appendix G** - Referral of Children at Risk).

**It is important to note that the EIP and foster care system have a different definition of children at risk** (see Section on “Terminology”).

### EIP Evaluation

#### *Children Suspected of Disability*

The Early Intervention Official/Designee must designate an initial service coordinator for children who are referred due to being suspected of having a disability (e.g., developmental delay or a diagnosed condition with a high probability of developmental delay). The initial service coordinator provides the family with information about the EIP; informs the family of their rights and safeguards; reviews the list of evaluators; obtains insurance/Medicaid information and other relevant information from the family; and assists the family in identifying and applying for Medicaid, Child Health Plus and other public benefit programs for which the family may be eligible. A multidisciplinary evaluation, which may include a screening, is conducted with the child and family to determine if the child is eligible for early intervention services and to gather information about the family’s and child’s strengths and needs that will assist in decisions about services.

#### *Children with an Established Diagnosed Condition*

A child who has an established diagnosed condition with a high probability of delay at the time of referral is eligible for early intervention services based upon the diagnosis. However, s/he must participate in a multidisciplinary evaluation to confirm eligibility for the Program and prepare for the Individualized Family Service Plan meeting.

### Development of an Individualized Family Service Plan (IFSP)

If the child is eligible for early intervention services, an IFSP meeting must occur within 45 days of the receipt of the child’s referral. At the IFSP meeting, the IFSP team, which includes the parent, initial service coordinator, evaluator, EIO/D, and any other person, such as the child’s primary health care provider or child care provider, who the parent or the initial service coordinator invite, with the parent’s consent, identify desired outcomes and specify early intervention services to be provided in a written IFSP. Once the parent and the EIO/D agree to the IFSP, the parent selects an ongoing service coordinator who is responsible for ensuring that services provided to the child are consistent with the IFSP. The child and family will receive the services agreed to in the IFSP. The IFSP is reviewed at six-month intervals and evaluated

annually by the EIO/D, service coordinator, the parent and service providers to determine if desired outcomes have been achieved, and if services need to be modified.

### Transition of Children from the EIP at Age Three

Eligibility for early intervention services ends at a child's third birthday, unless the child will be transitioning to preschool special education services. A child who will be transitioning to preschool special education services may be eligible to stay in the EIP past the child's third birthday, depending upon the child's birth date.

### **Parent Participation in the Early Intervention Program**

The EIP is a voluntary program. Parents have the option to participate in the program, and they may accept or reject some or all early intervention services for the child. However, if there is a court order requiring a child to participate in the EIP, the parent(s) must comply with the terms of the court order, and the EIO/D must ensure the provision of evaluation or other EI services according to the terms of the court order. Even when there is a court order, the parent(s) should be engaged in the evaluation and provision of services to the maximum extent possible.

Where the parent is unavailable and/or availability is limited due to life circumstances such as the parent residing far from the child; the parent residing in an institution; the parent's location is unknown; or, the parent does not want to be involved or is prohibited from decision-making regarding the child, the EIO/D is responsible for determining the need for a surrogate parent for the eligible child. The appointment of a surrogate will not be necessary in all instances. To determine whether a surrogate parent is needed with regard to a child in foster care, the EIO/D, in consultation with the local Commissioner of Social Services or designee, should make reasonable efforts to determine if the parent is available.

If the parent is available, the EIO/D, service coordinator and the LDSS Foster Care Caseworker should take steps to encourage the parent to be involved in the IFSP process and in service delivery. If the parent is determined to be unavailable or parental rights have been terminated or voluntarily surrendered, the EIO/D is responsible for appointing the surrogate parent for the purpose of the EIP. The EIO/D and the LDSS Foster Care Caseworker should consult with each other prior to the appointment of a surrogate parent for the child. A parent can voluntarily appoint a surrogate parent upon written consent. A surrogate parent has all the rights and responsibilities under the EIP necessary to enable the child to fully participate in the EIP. This can be a very complex issue and is discussed more fully in the section "Appointing a Surrogate Parent in the Early Intervention Program."

### **Service Coordination in the Early Intervention Program**

Service Coordination must be provided to all children referred to an EIO/D as suspected of having a disability. Since infants and toddlers with disabilities require a comprehensive array of services that may be provided by multiple agencies or individuals, federal and state laws require the provision of a service coordinator who is responsible for ensuring communication,

collaboration, and coordination among providers of service to eligible children and families. The service coordinator must be approved by the EIP to provide EI service coordination services.

There are two types of service coordinators in the EIP - an initial service coordinator and ongoing service coordinator. The EIO/D assigns the initial service coordinator upon the referral of a child thought to be an eligible child. The initial service coordinator has primary responsibility for ensuring that the parent is informed about the EIP and their rights under the Program; securing the essential information and consent from the parent necessary for participation in early intervention services; and assisting parents in selecting an evaluator and obtaining a screening and/or multidisciplinary evaluation for the child. At the initial IFSP meeting, the parent selects the ongoing service coordinator from a list of approved service coordinators who are under contract with the municipality in which the eligible child resides. The ongoing service coordinator is responsible for coordinating the services provided by various service providers included in the IFSP; working with the family to enhance the child's development; monitoring the child's progress to identify changes needed in the plan; preparing and coordinating the six-month and annual review of the family service plan; and facilitating the child's transition out of the EIP.

## **THE CHILD WELFARE SYSTEM**

### **Background**

Article 6 of the Social Services Law establishes the child welfare system and describes procedures for placement of children into foster care. Article 10 of the Family Court Act sets forth the standards and procedures for child protective proceedings, including the placement of abused or neglected children in the custody of a relative or other suitable person or the Commissioner of Social Services. The Social Services Law also sets forth provisions for the voluntary placement of children into foster care. In the 57 counties outside of New York City and the St. Regis Mohawk Tribe, Local Departments of Social Services (LDSS) administer child welfare services, including child protective, preventive, foster care and adoption services.

Children placed by Family Court order in the custody of the local Commissioner of Social Services or the St. Regis Mohawk Tribe are considered to be in foster care. In New York City, the Administration for Children's Services (ACS) administers the child welfare system and its services. Children in foster care in New York City are placed in the custody of the Commissioner of the ACS. The rules governing the actual care of and services available to foster care children are the same, whether placement occurs in New York City or the rest of the state.

New York State's child welfare policy primarily focuses upon the safety of the child. When a child must be removed from the parent's home, the least restrictive setting must be provided, and work must begin immediately on a permanency plan for the child. Many children are placed in foster care as a result of a child protective proceeding. Children are also placed into foster care on a voluntary basis. Generally, a child placed in foster care is placed in the care and custody of

the local commissioner of social services. The child's parent retains legal rights and responsibilities for the child.

In cases where the parent voluntarily surrenders guardianship and custody, or where the Family Court terminates the parents' rights, the parent no longer has guardianship and custody of the child. The EIP would consider such children who are in the guardianship and custody of the Local Commissioner of Social Services as "wards of the state." For all children in foster care, a case manager and case planner, are assigned and is responsible for foster care case planning while the child is in foster care status. For purposes of this protocol, the case manager and the case planner will be referred to as the "LDSS Foster Care Caseworker."

## **Foster Care Services**

### Foster Care Placement

Districts must place foster care children in foster homes, agency operated foster boarding homes, group homes or institutions directly or through an approved authorized agency. While in some cases, the Family Court has the authority to order placement of a child into a particular foster care arrangement, the legal care and custody of the child remain with the LDSS/ACS. The local district with legal custody of the child retains fiscal responsibility for the child.

Foster family homes are private homes in which a single person or family is certified or approved to provide care to a specified number of children at any given time. Young children are usually placed in foster family homes. Foster family homes include approved relative homes, commonly called "kinship" placements. Early intervention professionals should understand that in the case of informal kinship arrangements, where the LDSS Commissioner does not have legal custody of the child, the adult relative with whom the child is residing does not always have legal responsibility for the child. These children may not be known to the LDSS Commissioner and do not have a formal relationship with the LDSS (i.e., they will not have a caseworker). Under these circumstances, when no legal guardian has been appointed, the Early Intervention Official must determine the need for a surrogate parent (see the section - "Appointing a Surrogate Parent in the EIP").

Children in foster care may also be placed in congregate care settings including:

- institutions, which provide care for 13 or more children;
- group residences, which are institutional settings with a maximum of 25 children;
- group homes, which are family like settings serving not less than seven or more than 12 children; and,
- agency operated boarding homes, which are family-like settings serving not more than six children unless they are part of a larger sibling group.

### Medical Evaluation

All children in foster care are required to receive a basic medical evaluation within 30 days of the child entering foster care, with follow-up assessments, evaluations and/or treatment occurring

as recommended by the physician. While the evaluation should include a developmental assessment, it does not replace the multidisciplinary evaluation required by the EIP. However, with parental consent the results of the evaluation should be made available to the EIP multidisciplinary evaluation team. It is important for the initial service coordinator to work with the LDSS caseworker and the child's parents to determine what evaluations have occurred prior to the early intervention referral and to assure that the child is under the care of a primary care physician.

### Permanency Planning

Policies related to placement in the least restrictive setting, permanency planning and other standards for the provision of foster care services are the same throughout the state. Permanency planning for children, i.e., supporting the process of reunification with the natural family, as long as it can be established that it is consistent with the safety of the child, is a key policy in the foster care system. There is a clear intent for foster care to be a short-term, interim step in a child's journey to permanency. Achievement of permanency objectives for children in care, in accordance with a child's needs for emotional security and healthy development, must be considered in any decision-making regarding the child.

### **Role of LDSS Foster Care Case Workers**

The LDSS will assign a case manager to each child in foster care. The case manager is responsible for placement of the child and for authorizing the provision of preventive services that are included in a written child and family service plan. The case manager develops permanency plans. In some districts the case manager is also responsible for coordination and evaluation of provision of those preventive services needed by a child and his/her family to prevent disruption of the family and to facilitate the child's reunification with his/her natural family. In districts that use foster care agencies, a case planner assigned from the agency may be responsible for this function. Even when the contract agency case manager is the day-to-day contact and planner for the child, the contract agency is required to have the case manager sign off on all decisions/changes regarding the child's care.

For purposes of this protocol, the case manager and the case planner will be referred to as the "LDSS Foster Care Caseworker."

## **COMMUNICATION AND COLLABORATION BETWEEN THE EARLY INTERVENTION PROGRAM AND THE CHILD WELFARE SYSTEM**

### **System Focus**

While both the EIP and the foster care system are concerned with the well being of children and families and are complementary to each other, each system has its unique focus and responsibilities. The child welfare system provides services to children whose families, for a variety of reasons, cannot provide adequately for them. The focus of the foster care system is to provide a stable, safe home environment for the child; to see that health, education and other necessary services are available to the child; and, to provide the child with a safe permanent

living arrangement. The early intervention system provides many different types of early intervention services to infants and toddlers who meet the eligible criteria for the program. Many children participating in the child welfare system can benefit from, and will be found eligible for, early intervention services, and, conversely, some children in the early intervention system will need the services of the child welfare system. It is important that professionals involved in both systems understand how and when their roles and responsibilities intersect, if children served by each system are to receive the full benefits and supports these systems have to offer.

### **Communication Between Professionals in the Two Systems**

Professionals working in each system must communicate and work together when involved with the same child and family. While meeting their own program responsibilities to facilitate early intervention services and family supports, it is critical that EIP staff understand decisions made and information conveyed by child welfare system professionals. Child welfare professionals, in turn, should understand early intervention requirements and utilize early intervention services to enhance the development of a child and the capacity of his/her caregivers when a child is developmentally compromised.

#### EIP Professional's Role

It is important for the EIP to inform the LDSS Foster Care Caseworker about the child's early intervention eligibility status, service plan, and progress, so that the LDSS can more effectively carry out its responsibilities for general management of the child's foster care program, taking into consideration what is happening to the child while s/he is receiving early intervention services.

#### LDSS Foster Care Professional's Role

It is important for the LDSS Foster Care Caseworker to keep the EIO/D and EI service coordinator apprised about the child's placement, location, health/medical status and permanency plan status. Ongoing awareness of the child's whereabouts and custodial situation will allow the local EIP to develop and implement a supportive and appropriate service plan, and to appropriately claim and receive reimbursement from the State Program. This collaborative relationship will enable EIP staff to be a resource to child welfare professionals when a child in foster care is identified as having a disability or is suspected of having a delay in development, and/or when a parent or foster care parent has concerns about coping with a child with a disability.

### **Terminology**

Professionals in both systems should also understand the terminology used by each system. Key terms that should be understood as they are used in one or both systems are as follows:

### *Child At Risk*

The EIP defines a child at risk as one who is at risk for developmental delays or disability. In the foster care system, a child at risk is one who experiences parental neglect or abuse, is at risk of out-of-home placement or other compromising circumstances. It is important for LDSS and other staff working in the foster care system to understand that a child who is at risk and is placed in the foster care system may not be eligible for early intervention services. A child must meet the state's EIP eligibility criteria as previously described to receive early intervention services.

### *Least Restrictive Setting/Natural Environment*

In the child welfare system, the term "least restrictive setting" means placing a child in the most home-like setting in which the child can be maintained safely and receive all services specified in their service plan. This setting should permit the child to retain contact with persons, groups, and institutions with whom they have been involved, or to which the child will be discharged. This is similar, but not the same, as the EIP concept of natural environments. Natural environments are defined by the EIP as settings that are natural or normal for the child's age peers who have no disability, including the home, a relative's home when care is delivered by the relative, child care setting, or other community settings in which children without disabilities participate. Early intervention services are provided in conformance with an IFSP and, to the maximum extent appropriate, in natural environments.

## **MANDATED REPORTING**

Children are reported to the child welfare system when the parent's action or inaction causes the child harm or places the child at imminent risk of harm. This will warrant a report to the State Central Register of Child Abuse and Maltreatment (1-800-342-3720) for investigation. Two districts, Onondaga (315) 422-9701 and Monroe (585) 461-5690, maintain their own child abuse and maltreatment hotline numbers. Title 6 of Social Services Law on Child Protective Services (Sections 413 and 414) describes which professions are required to report cases of suspected child abuse maltreatment to the State Central Register of Child Abuse and Maltreatment for investigation (see **Appendix D** -Mandated Reporters of Child Abuse and Maltreatment). Early Intervention Providers who are Child Abuse and Maltreatment Mandated Reporters under the Social Services Law may call the Mandated Reporters' hotline number (1-800-635-1522). Any person who is not a mandated reporter may make a report if they believe there is reasonable cause to suspect child abuse or maltreatment.

Reporting of child abuse or maltreatment is a serious step and should not to be taken lightly. Each child/family's situation should be considered very carefully prior to making a report. There may be situations that EIP professionals encounter that require a report to the State Central Register of Child Abuse and Maltreatment (see **Appendix F** for definition of Child Abuse and Maltreatment). In addition, there may be circumstances under which a parent's refusal to participate in EI services may need to be considered in the decisions of making a report of child abuse or maltreatment (see **Appendix E** for the description of Medical Neglect).

Under the EIP, a service coordinator may be a mandated reporter by virtue of his/her professional license or certification and of their seeing the family in that status. EIO/Ds and agencies that employ service coordinators must establish policies to ensure that service coordinators inform a responsible party about any suspected cases of child abuse and maltreatment.

Since not all early intervention service providers are mandated reporters by virtue of their professional licenses or certification, EI agencies and individuals who are under contract to provide early intervention services should develop procedures for non-mandated reporters related to the reporting of child abuse and maltreatment.

### **APPOINTING A SURROGATE PARENT IN THE EARLY INTERVENTION PROGRAM**

EIP regulations require the EIO/D to determine if a child needs a surrogate parent and to appoint a qualified surrogate parent to assume the responsibilities of a parent and to represent the child in all matters related to participation in the EIP when:

- A child has no available parent or person acting in place of a parent that can be identified.
- The whereabouts of the parent(s) is unknown.
- The child is a Ward of the State, (a foster care child in the custody and guardianship of the local commissioner of social services).

The role of a surrogate parent is to make decisions regarding the child within the early intervention system. The surrogate parent is afforded the same rights and responsibilities as accorded to the parent and represents the child in all matters related to: screening, evaluation, IFSP development and implementation, provision of early intervention service, periodic review of IFSP services and due process procedures. A surrogate parent has access to all early intervention records concerning the child and due process rights related to those records.

When a child is in the foster care system and is referred to the EIP, the EIO/D should consult with the social service district to determine whether parental rights have been terminated or voluntarily surrendered, and whether the parent is available. This also provides an opportunity to share information; identify any potential barrier to parental consent and participation; and to determine the need for, and, as appropriate, identify a suitable surrogate parent.

Where the parent is unavailable and/or availability is limited due to life circumstances such as the parent residing far from the child; the parent residing in an institution; the parent's location is unknown; or, the parent does not want to be involved or is prohibited from decision-making regarding the child, the EIO/D is responsible for determining the need for a surrogate parent for the eligible child. The appointment of a surrogate will not be necessary in all instances. To determine whether a surrogate parent is needed, the EIO/D in consultation with the local Commissioner of Social Services or designee, should make reasonable efforts to determine if the parent is available. If the parent is available, the EIO/D, service coordinator and the LDSS Foster Care Caseworker should take steps to encourage the parent to be involved in the IFSP process and in service delivery. If the parent is determined to be unavailable or parental rights

have been terminated or voluntarily surrendered, the EIO/D is responsible for appointing the surrogate parent for the purpose of the EIP. The EIO/D and the LDSS Foster Care Caseworker should consult with each other prior to the appointment of a surrogate parent for the child. A parent can voluntarily appoint a surrogate parent upon written consent.

**The final decision regarding the appointment of a qualified surrogate parent rests with the EIO/D.** The appointment or removal of a surrogate parent can occur at any time while the child is in the early intervention system. The EIO/D can appoint a different surrogate parent when appropriate and necessary (e.g., the surrogate parent is no longer willing and able to participate, or the surrogate parent fails to fulfill his or her duties). The EIO/D can remove the appointment of the surrogate parent, if it is determined that the parent is able to fully participate in the EIP.

The EIO is responsible for selecting a surrogate parent who is qualified and willing to serve and who:

- has no interest that conflicts with the interests of the child;
- has knowledge and skills that ensure adequate representation of the child;
- if available and appropriate, is a relative who has an ongoing relationship with the child; or,
- is a foster parent with whom the child resides.

Under the federal Individuals with Disabilities Education Act (IDEA), the surrogate parent may not be an employee of any state agency (e.g., LDSS Commissioner, caseworker, case manager, case planner) or a person or employee of a person providing early intervention services (EIO/D, EI service coordinator) to the child. While the LDSS Commissioner can consent to medical, dental and hospital services for children who are in the commissioner's custody, IDEA specifically excludes state officials from acting as a surrogate parent in the EIP.

#### Parental Rights Not Terminated or Voluntarily Surrendered and the Parent is Available to Participate

Unless parental rights have been terminated or surrendered, the EIP and foster care systems should take steps to encourage the parent to be involved in the IFSP process and in early intervention services delivery. This protocol assumes the parent will continue to be actively involved in the EIP process, if the parent is available. However, even when the parent is available, there may be circumstances under which the EIO/D determines that it is in the best interest of the child to appoint a surrogate. The EIO/D should consult with LDSS Foster Care Caseworker before appointment of a surrogate parent. If a surrogate is appointed in such a case, the EIP should continue to try to involve the parent.

#### Parental Rights Not Terminated or Voluntarily Surrendered and the Parent is Unavailable or Chooses Not to Participate

In some cases, the parent still retains parental rights but is unavailable and/or availability is limited due to life circumstances, including that the parent resides far from their child; the parent resides in an institution; the parent's location is unknown, the parent does not want to be involved, or is prohibited from decision-making regarding the child; or the child is placed in the

care and custody of the local social service commissioner. The LDSS Foster Care caseworker should immediately advise the initial EI Service Coordinator and EIO/D that the parent is absent and cannot participate or chooses not to participate, so that EIO/D may consult with the LDSS and, as appropriate, appoint a surrogate parent for the child. Whenever possible, the EIP should continue to try to involve the parent in early intervention services.

When it is not known if the parent is available, the EIO/D should make at least two contacts (reasonable efforts) at the last known address in order to locate the parent and ascertain his/her willingness to be involved in the EIP, before appointing a surrogate. The attempts at locating the parent can also be accomplished in conjunction with LDSS.

#### Parental Rights Terminated or Voluntarily Surrendered

When parental rights have been terminated or voluntary surrender of guardianship and custody has occurred, the EIO/D must appoint a surrogate parent for any eligible or potentially eligible child.

**The EIO should designate the foster care parent or an available relative as the *surrogate parent* for the EIP whenever possible and appropriate.**

The New York State Office of Children and Family Services letter dated 5/27/99 to the local Commissioners of Social Services provides clarification on the authority of local social services districts in regard to foster children who are participating in the EIP (see **Appendix I** - Office of Children and Family Services Commissioner Letter).

### **FINANCIAL RESPONSIBILITY**

Nearly all foster care children are eligible for Medicaid. However, some foster care children will retain private commercial insurance. The LDSS is responsible for determining the child's eligibility for Medicaid, and for pursuing third party (private commercial health insurance) coverage where appropriate.

#### **Early Intervention Program**

As with all other children in the EIP, the municipality is responsible for claiming Medicaid or commercial insurance prior to submitting any claims to the State. When children in foster care are placed outside of their county of residence the following fiscal responsibilities apply:

- The municipality of residence (the municipality in which a child or child's family lived at the time the local social service district assumed responsibility or custody of the child) is financially responsible for the local contribution of the approved cost of early intervention services.

- The municipality of current location (the municipality in which a child currently resides) is responsible for delivering early intervention services to the child and implementing the child/family's IFSP. The municipality of current location may be different from the municipality where the child or his/her family resided at the time a social services district assumed responsibility for the placement of the child. The municipality of current location receives 100% reimbursement from the State, which is offset by the local contribution due. The municipality of residence is financially responsible for the local contribution of the approved cost of early intervention.

### **Foster Care Services**

The LDSS that assumed custody retains financial responsibility for the foster care services provided to the child.

The LDSS will have information regarding the child's Medicaid and commercial insurance and should share this information with the municipal EIP. The municipal early intervention initial service coordinator should obtain all relevant Medicaid and commercial insurance from the LDSS Foster Care Caseworker.

## **Protocol for Interaction Between EIP and Local Districts of Social Services**

The following Foster Care Protocol identifies main procedures and steps that should occur within the Early Intervention System. However, it should be noted that this Protocol is not an inclusive list of all procedures and steps that need to occur. Both LDSS staff and municipal EI staff should be familiar and have sufficient knowledge regarding EI procedures and steps.

The EIP term for 'parent' includes, birth, adoptive or person in parental relation to the child. The EIP term 'in parental relation' means a child's legal guardian, standby guardian, custodian or person acting in the place of a parent (grandparent or stepparent). For the purposes of this protocol the term 'parent' will be used to represent all of the above-mentioned relationships.

## **CHILD FIND FOR THE EARLY INTERVENTION PROGRAM**

### **RESPONSIBILITIES/ PROCEDURES**

#### **LDSS Foster Care Caseworker:**

- Refers all children in foster care to primary health care providers for a basic medical evaluation health assessment, developmental screen and medical care.
- Is familiar with the New York State Early Intervention Program (EIP).
- Identifies children in foster care with suspected disabilities and developmental delay. This information may be obtained from personal observation, parent/caregiver/foster care information, primary health care provider, and review of health records. A formal evaluation or examination is not necessary for a referral to the EIP.
- Shares basic information about the EIP with families.

#### **EIO/Designee:**

- Maintains a system to identify children with disabilities and developmental delay(s) within the municipality.
- Educates the general public, especially primary referral sources, on how to make referrals to the EIP.
- Ensures primary referral sources, including LDSS Foster Care Caseworkers and health care providers, and foster parents serving children in foster care, understand how to refer children to the EIP.

## **REFERRAL TO THE EARLY INTERVENTION PROGRAM**

### **RESPONSIBILITIES/PROCEDURES**

#### **LDSS Foster Care Caseworker:**

- Functions as a primary referral source (see **Appendix C - EI Required Primary Referral Sources**) under EIP regulations and must refer children at risk (see **Appendix G – Referral of Children at Risk**) who are suspected of having a disability to the municipality where the child resides within two working days of identifying such child. If a child’s parent cannot be reached or located to discuss a referral, and the caseworker believes the child may need early intervention services, a referral should be made to the EIP.
- If feasible prior to referral, explains to the parent the reasons for referral, benefits of services and next steps; or, if feasible, after referral, informs the parent of the referral made by another party.
- If the parent objects to the referral, the LDSS Foster Care Caseworker should document the objection in the Uniform Case Record (UCR) and should follow up in two months to see if the parent will reconsider. The LDSS should refer the child to a primary health provider and work with the primary care provider to conduct developmental surveillance. The health care provider is also a primary referral source to the EIP and should work with the parent to refer the child.
- If circumstances warrant (e.g., child is severely disabled or has significant delays), the LDSS Foster Care Caseworker may alert the LDSS attorney, when necessary and appropriate, for an EIP referral and evaluation and, if appropriate, for services.
- If the child is in the process of being placed in foster care, and there is no firm address for the child, the LDSS Foster Care Caseworker uses the foster care agency or county social services address as the child’s address for referral purposes, until a more permanent address is identified.
- At time of referral, inform the EIO/D if parental rights have been terminated or voluntarily surrendered and if the parent is not available or chooses not to participate.

#### **EIO/Designee:**

- Receives all referrals, including referrals made by foster care parents.
- Promptly designates an initial EI Service Coordinator.
- Promptly informs the LDSS Commissioner or designee when a child in foster care has been referred.
- Determines if a surrogate parent needs to be appointed because a parent is unavailable, or if parental rights have been terminated or voluntarily surrendered.
- Appoints a surrogate parent when appropriate.

<p><b>Recommendations for consideration at the local level</b></p> <ul style="list-style-type: none"><li>• There are state-sponsored early intervention training opportunities for primary referral sources through Department of Health training contracts. Child welfare system managers should be aware of and promote attendance of LDSS staff at this training.</li><li>• Child Welfare System and municipal EIP managers should collaborate and develop a general consent form to share information regarding the child that will meet both system requirements and facilitate sharing of information.</li></ul>
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## **INTAKE INTO THE EARLY INTERVENTION PROGRAM**

### **RESPONSIBILITIES/PROCEDURES**

#### **LDSS Foster Care Caseworker:**

- Receives notification of designation of an initial EI Service Coordinator for the child.
- Facilitates contact with the foster parent or agency providing for the care of the child when not in a foster care home and initial EI Service Coordinator.
- Shares information about previous health/developmental evaluations or other information about the child's development progress with the initial service coordinator.
- Collaborates with the EIO/D, parent/surrogate parent, foster parent when the child and/or family are in apparent immediate need of early intervention services before the evaluation and agrees to the provision of a temporary IFSP - called an interim Individualized Family Service Plan (e.g., a child who has been diagnosed with failure to thrive- the need for nutritional or therapeutic intervention related to feeding).

#### Parental Rights Not Terminated or Voluntarily Surrendered and the Parent is Available to Participate

- Assists in arranging a prompt meeting with the initial EI Service Coordinator and the parent.

#### Parental Rights Not Terminated or Voluntarily Surrendered and the Parent is Unavailable or Chooses Not to Participate

- Immediately advises the initial EI Service Coordinator and EIO/D that the parent is absent and cannot participate or chooses not to participate, so that EIO/D may consult with the LDSS and, if appropriate, appoint a surrogate parent for the purposes of receiving early intervention services.

#### Parental Rights Terminated or Voluntarily Surrendered

- Immediately advises the EIO/D if parental rights were terminated or if the parent voluntarily relinquished guardianship and custody, and of the terms of any court orders, so that the EIO/D may appoint a surrogate parent for the purposes of the EIP.

#### **EIO/Designee:**

- Promptly contacts the LDSS Foster Care Caseworker to notify him/her of a referral and intake of a foster care child into the EIP and to:
  - verify the residence of the child;
  - determine if parental rights were terminated or if the parent voluntarily surrendered;
  - determine if there are any court orders that must be followed; and,
  - identify and locate the birth parent.
- Obtains parental consent to exchange information about the child with others (general release

or selective release which specifies names or category of those individuals with whom information will be exchanged).

Parental Rights Not Terminated or Voluntarily Surrendered and Parent is Available to Participate

- Notifies the parent and LDSS Foster Care Caseworker of the designation of an initial EI Service Coordinator, in writing. This notification should include the name, address and telephone number of the initial EI Service Coordinator.
- Notifies the initial EI Service Coordinator of the name of the LDSS Foster Care Caseworker and the fact that parental rights were not terminated.
- Makes a reasonable effort to forward a copy of the EIP parent handbook to the parent.
- When necessary and appropriate, collaborates with the LDSS Foster Care Caseworker and agrees to an interim IFSP with the parent and initial EI Service Coordinator.
- Obtains parental consent to obtain and to share EIP information with the child's primary health care provider.
- Obtains parental consent to include the foster care parent in EIP planning and services, as appropriate.
- Explains to the parent the process to voluntarily appoint a surrogate parent through written consent.

Parental Rights Not Terminated or Voluntarily Surrendered and the Parent is Unavailable or Chooses Not to Participate

- Immediately consults with the LDSS regarding who could serve as a qualified and appropriate surrogate parent for the child, for the purposes of receiving early intervention services. Makes reasonable efforts to facilitate the parent's involvement in early intervention services. Final decision regarding the appointment of a qualified surrogate parent rests with the EIO/D.
- Appoints a surrogate parent (the foster parent can be the surrogate parent, unless this is not practical, i.e., the child will be moved shortly, etc.) and documents the appointment of the surrogate parent in the child's record.
- Notifies the surrogate parent and LDSS Foster Care Caseworker of the designation of an initial EI Service Coordinator, in writing. This notification should include the name, address and telephone number of the initial EI Service Coordinator.
- Notifies the initial EI Service Coordinator of the surrogate parent and LDSS Foster Care Caseworker.
- Forwards a copy of the EIP parent handbook to the surrogate parent (and, when possible, to the parent) by mail or other suitable means.
- When necessary and appropriate, collaborates with the LDSS Foster Care Caseworker and agrees to an interim IFSP with the surrogate parent and initial EI Service Coordinator.

Parental Rights Terminated or Voluntary Surrendered Steps and procedures are the same as above section "Parental Rights Not Terminated or Voluntarily Surrendered and the Parent is Unavailable or Chooses Not to Participate."

**Initial EI Service Coordinator:**

- Promptly contacts the LDSS Foster Care Caseworker to verify:

- if not known, whether parental rights were terminated (if so, ensures this is documented in the record and advises the EIO/D, if necessary);
- the identity of the parent;
- the child's foster care Medicaid number to bill for early intervention services;
- the child's foster care Medicaid client ID number will be in the following format:
  - NYC: "L", letter, 5 numbers, letter (LX99999X)
  - Rest of State: letter, letter, 5 numbers, letter (XX99999X)

**The Medicaid client ID number should not be confused with a managed care plan number.**

- Documents above information in the service coordination record.
- Notifies the EIO/D of the above information including Medicaid information.
- Documents the appointment of a surrogate parent in the service coordination record.
- Promptly arranges to meet with the parent/surrogate parent to inform them of their rights and entitlements under EIP, and arrange for a multidisciplinary evaluation.
  - Assists the parent/surrogate parent to prepare for the evaluation by explaining the evaluation process, including the opportunity to engage in a voluntary family assessment process with the evaluator.
  - Explains the role of EI Service Coordinator and how it differs and does not replace the role of the LDSS Foster Care Caseworker; impress upon the parent/surrogate parent the need to keep the LDSS Foster Care Caseworker informed about the child's progress in the early intervention system.
  - Obtains parent/surrogate parent consent to share information with the foster parent, if other than the surrogate parent, and consent to the participation of the foster care parent in the planning for and delivery of early intervention services.
  - Assists the parent/surrogate parent to select an evaluator.
- When available, forwards information to the evaluator about previous health/developmental evaluations or other information about the child's health/developmental progress that was obtained from the LDSS Foster Care Caseworker, that may influence the EI evaluation of the child.
- Forwards the consent to share information with the foster parent to the EIO/D.

**Recommendations for consideration at the local level**

EIO/Ds and LDSS should establish policies and procedures to protect the confidentiality of the foster care parent, including the foster care parent's name and address, when there is a safety issue regarding the foster care child and/or foster care parent. Certain information, which may not be released to the parent, should be redacted or removed prior to the release of the Early Intervention Program record to the parent.

## **EARLY INTERVENTION EVALUATION PROCESS**

### **RESPONSIBILITIES/PROCEDURES**

#### **EI Evaluation Provider:**

- Obtains parent/surrogate parent consent to conduct the multidisciplinary evaluation to determine eligibility.
- If the Foster Care Parent has not been assigned as the surrogate parent, obtains consent from the parent/surrogate parent to contact the foster parent to gain a complete picture of the child's daily development and needs for use in the evaluation process.
- Conducts the multidisciplinary evaluation.
- Offers and explains to the parent, surrogate parent and/or foster care parent the opportunity to engage in the voluntary family assessment component of the evaluation that determines resources, priorities, and concerns of the family related to enhancement of the child's development. The parent, surrogate parent, and the foster care parent may all have the opportunity to engage in the family assessment process with the evaluation team. Participation in the family assessment is voluntary on the part of the parent, surrogate parent and/or foster care parent.
- If consent has not been obtained, encourages the parent or surrogate parent to provide parent consent to send the evaluation report to the child's primary health care provider.
- Reviews the results of the evaluation with the parent or surrogate parent.
- Issues an evaluation report and summary in time to conduct the IFSP meeting within 45 days of referral of the child to the EIO/D.
- Sends the evaluation report/summary to the parent/surrogate parent, EIO/D, initial EI Service Coordinator and LDSS Foster Care Caseworker. With consent, forwards a copy of the evaluation report/summary to the child's primary health care provider and to the foster care parent, if the foster parent is not the surrogate parent.

#### **EI (Initial) Service Coordinator:**

- Upon receipt of the evaluation report, reviews the report with the parent/surrogate parent and determines if the parent/surrogate parent understands the report.
- Requests additional diagnostic information regarding the condition of the child, if appropriate, with parent consent and approval of the EIO/D.
- If parent/surrogate parent consent was not obtained to forward the evaluation summary/report to the child's primary health care provider and the foster care parent, makes another attempt to obtain such consent.

#### If child is found ineligible

- Informs the parent/surrogate parent of the right to due process, which includes the right to a second evaluation, to request mediation or an impartial hearing to resolve a dispute regarding eligibility or services, and the right to file a systems complaint if they feel that there has been a violation of EI regulations.

- Informs the parent/surrogate parent of other available services and offers assistance with appropriate referrals to other community services.
- Discusses evaluation results and parent/surrogate parent decision about due process with LDSS Foster Care Caseworker.
- If found ineligible for EI services, but considered “at risk”, the child would be tracked and screened through the EI tracking system for appropriate periodic developmental surveillance.

If child is found eligible

- Informs the parent/surrogate parent about the IFSP meeting and process, including who may attend.
- Informs the parent/surrogate parent about selection of an ongoing EI Service Coordinator at the IFSP meeting and the role of the ongoing EI Service Coordinator.
- Assists the parent, surrogate parent, and/or foster care parent (with parental consent) to prepare for the meeting to develop the individualized family service plan, including helping them understand the child’s evaluation(s) and identifying their priorities, resources, concerns related to their child’s development.
- Informs the LDSS Foster Care Caseworker, if parent/surrogate parent refuses early intervention services.
- If IFSP is developed and the foster care parent, who is not the surrogate parent, refuses EI services, the EI ongoing Service Coordinator and LDSS Foster Care Caseworker need to discuss the situation.

**EIO/Designee:**

- Reviews evaluation reports and ensures eligibility has been determined according to State EIP criteria.
- Addresses concerns raised by the initial EI Service Coordinator, evaluator, LDSS Foster Care Caseworker, parent, surrogate parent and foster care parent.
- Authorizes additional evaluations or components of the evaluation when the parent/surrogate parent or the Service Coordinator request and when necessary and appropriate.

**LDSS Foster Care Caseworker:**

- Shares information about previous health/developmental evaluations and/or other information that will influence the EI evaluation of the child with the initial EI Service Coordinator and/or evaluator.
- If circumstances warrant (e.g., child severely disabled or child has significant delays), LDSS Foster Care Caseworker may alert the LDSS attorney to request a court order, when necessary and appropriate, to arrange for provision of evaluation and services.
- Provides and shares information regarding the foster care placement that may impact on the EI service delivery and feasibility of services.

**Recommendations for consideration at the local level**

Wherever possible, the selected Early Intervention evaluator should have knowledge of relevant information concerning the child welfare system, and should have access to contact information for the LDSS Foster Care Caseworker (name, telephone number, etc.).

## **THE INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)**

### **RESPONSIBILITIES/PROCEDURES**

#### **EIO/Designee:**

- Arranges the IFSP meeting at a time and place convenient for the parent.
- Before an IFSP meeting, sends written notice to required attendees (Parent/ Surrogate Parent, EI Service Coordinator, Evaluator, and Foster Parent with parental consent) and invitations to the LDSS Foster Care Caseworker and individuals requested by the parent/surrogate parent.
- Prepares for IFSP development by reviewing reports/documentation, discussing concerns with the EI Service Coordinator, evaluator, parent, surrogate parent, foster care parent, and LDSS Foster Care Caseworker, etc.
- Convenes the initial IFSP meeting within 45 days of referral of the child to the municipality.
- Convenes the IFSP team to review the IFSP at least every six months by meeting or other means amenable to the parent/surrogate parent.
- Convenes the IFSP team to evaluate the IFSP at least annually.
- Agrees to all or part of IFSP with the parent/surrogate parent.
- Documents the child's record with IFSP decisions and identifies which part of the IFSP was agreed to or disputed.
- Notifies the LDSS Foster Care Caseworker of the results of the IFSP, if the caseworker did not participate.
- Notifies the parent or surrogate parent of due process rights for IFSP services that are in dispute.
- Notifies the LDSS Foster Care Caseworker when the parent or surrogate parent exercises due process rights for IFSP services that are in dispute.

#### **EI Service Coordinator:**

- Discusses with the parent or surrogate parent the IFSP process.
- Informs parent or surrogate parent of the required participants and optional participants, including the foster parent that can be invited to the IFSP meeting.
- Informs parent/surrogate parent of the opportunity during the evaluation to participate in the family assessment process with the evaluator. Both the parent and the foster parent may participate in the voluntary family assessment.
- Participates in the joint development of the IFSP.

#### **EI Evaluator:**

- Participates in the joint development of the IFSP.
- Clarifies evaluation findings when necessary.

#### **LDSS Foster Care Caseworker:**

- Participates in IFSP development.

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- Documents the outcome of all IFSP meetings in the UCR and relates this information to permanency planning and planning for other services.
- Considers early intervention services, when coordinating permanency planning and other services.
- If foster parent did not participate in IFSP development, notifies them of how the plan will be implemented and their obligations when early intervention services are being delivered.

## **DELIVERY OF EARLY INTERVENTION SERVICES**

### **RESPONSIBILITIES/PROCEDURES**

#### **EIO/Designee:**

- Provides oversight and ensures the delivery of authorized early intervention services.
- Monitors early intervention services and promptly corrects problems such as late service delivery, use of unqualified personnel, gaps in service delivery, delivery of unauthorized services, etc.
- Oversees circumstances when child is unavailable for services, so that the IFSP team can make a review of the appropriateness of the IFSP.
- Monitors provider billing for services.
- Participates in due process as necessary.
- Coordinates with providers and ensures that a complete record of the child's participation in the EIP is maintained.
- Shares service-related information with the LDSS Foster Care Caseworker.

#### **Ongoing EI Service Coordinator:**

- Participates in the development of IFSPs.
- Implements the IFSP and monitors the delivery of services authorized in the IFSP.
- Coordinates the provision of all early intervention services.
- Ensures that the IFSP outcomes and strategies reflect the family's priorities, concerns and resources.
- Coordinates the performance of evaluations and assessments.
- Facilitates and participates in the review and evaluation of the IFSP.
- Corrects problems regarding delivery of early intervention services that are identified through reports by the parent/surrogate parent, foster parent, provider, LDSS Foster Care Caseworker, or EIO/D, and if unable to correct problems in a timely manner, contacts the EIO/D.
- Keeps LDSS Foster Care Caseworker informed of the child's progress.
- Participates in due process as appropriate.
- Documents the early intervention service coordination record.

#### **EI Service Provider:**

- Notifies EI Service Coordinator when child is unavailable for services.
- Communicates with parent or surrogate parent regarding child's progress.
- Participates in planning for child's discharge or transition from the EIP to other services.

#### **LDSS Foster Care Caseworker:**

- Participates in the ongoing development of IFSPs.
- Notifies the EIO/D and ongoing EI Service Coordinator, if the child changes

PROTOCOL  
CHILDREN IN FOSTER CARE WHO PARTICIPATE IN THE EARLY INTERVENTION PROGRAM

placement/location so that early intervention services are not disrupted.

- Notifies the EIO/D and ongoing EI Service Coordinator regarding the child's permanency goal, visitation schedule and court orders, so these can be considered when planning for or delivering early intervention services.
- Documents information about the child's participation in the EIP in the UCR.

## **MEDIATION AND IMPARTIAL HEARING DISPUTES ON ELIGIBILITY/IFSP IN THE EARLY INTERVENTION PROGRAM**

### **RESPONSIBILITIES/PROCEDURES**

#### **EIO/Designee:**

- Provides written notice to parent or surrogate parent of the right to due process when:
  - child is found ineligible;
  - parent/surrogate parent and EIO/D disagree about the services that are included in the IFSP (type, quantity, setting, etc.);
  - parent/surrogate parent is dissatisfied with service provision, and the problem cannot readily be resolved.
- Receives request for mediation from parent/surrogate parent and forwards to community dispute resolution center.
- Receives notice of impartial hearing from the Department of Health, Division of Legal Affairs.
- Participates in mediation and/or impartial hearing.
- Amends the record, including the IFSP, if applicable, according to mediation and impartial hearing decisions.
- Advises LDSS Foster Care Caseworker of decision and changes to IFSP resulting from mediation/impartial hearing.
- Implements terms of mediation/impartial hearing decisions.

#### **EI Service Coordinator:**

- Discusses due process rights with parent/surrogate parent when concerns cannot be readily resolved.
- Clarifies/answers questions from parent/surrogate parent regarding due process.
- Participates in mediation, if invited, and impartial hearing, if summoned.
- Amends the service coordination record, if applicable, according to mediation and impartial hearing decisions.
- Keeps LDSS Foster Care Caseworker apprised of due process decisions either by phone or in writing.
- Monitors services according to terms of mediation/impartial hearing decisions.

#### **LDSS Foster Care Caseworker:**

- Participates in mediation when invited and impartial hearing when summoned.
- Documents the UCR of any changes in the child's early intervention services as a result of due process decisions.

## **TRANSITION/DISCHARGE FROM THE EARLY INTERVENTION PROGRAM**

### **RESPONSIBILITIES/PROCEDURES**

#### **For all children transitioning from the EIP**

##### **EI Ongoing Service Coordinator:**

- Explains transition process to parent/surrogate parent and LDSS Foster Care Caseworker.
- Sets up a meeting to discuss the transition plan to preschool or other early childhood services.
- Participates in the IFSP and other meetings to discuss and plan for transition.
- If applicable, includes in the IFSP steps to be taken supporting the potential transition. The plan for transition should include procedures to prepare the child and family for changes in service delivery or to other appropriate early childhood and supportive services.
- Reviews information concerning the transition process with the parent/surrogate parent and LDSS Foster Care Caseworker.
- Links the child and parent/surrogate parent to other community services the child is potentially eligible for.
- Obtains parental consent for the transfer of appropriate evaluations, assessment, IFSP, and other pertinent records.

##### **LDSS Foster Care Caseworker:**

- Coordinates with the EI Ongoing Service Coordinator and the parent/surrogate parent on the referral process.
- Notifies the EIO/D and EI Ongoing Service Coordinator that the referral has been made.
- Attends the IFSP meeting and transition conference meeting.
- Documents the foster care record with the child's plan for transition from the EIP and discharge activities.
- In coordination with EI Ongoing Service Coordinator, facilitates the child's transition from the EIP as necessary.

#### **For children potentially eligible for the Preschool Special Education Program**

(See **Appendix H-** Criteria for Eligibility for Preschool Special Education Programs and/or Services.)

##### **EIO/Designee:**

- Discusses with the parent/surrogate parent the transition process.
- Notifies the LDSS Foster Care Caseworker and parent/surrogate of procedures to determine whether the child is eligible for services under Section 4410 of the NYS Education Law, which serves children ages 3-5 years with disabilities and developmental delay.

- Coordinates with the LDSS Caseworker to work with the parent/surrogate parent to develop a transition plan.
- For children referred to the CPSE, obtains parent/surrogate consent to transfer evaluations, assessments, IFSPs and other pertinent early intervention records to the CPSE.
- Arranges for a conference, with parental consent, with the service coordinator, the parent/surrogate parent, and the chairperson of the committee on preschool special education or designee to review the child's program options and to establish a transition plan, if appropriate.
- Invites the local social services commissioner/designee to participate in the conference.

**Board Of Education/CPSE:**

- CPSE requests written consent from the parent to conduct the individual evaluation.
- The Board of Education (BOE) must adhere to the Regulations of the Commissioner of Education Part 200, in the appointment of a surrogate parent to act in place of parents or guardians when a student's parents or guardians are not known, or when after reasonable efforts, the board of education can not discover the whereabouts of a parent or, the student is a ward of the State. The BOE appoints from the list of surrogate parents kept by the Board.
- With parental consent, the chairperson of the CPSE or designee participates in a conference with the parent/surrogate parent, service coordinator, to review program options for the child. (Note: the conference may also be an IFSP meeting and may be combined with the initial CPSE meeting).

**Recommendations for consideration at the local level**

Develop an interagency agreement between the municipal EIP and LDSS that will address the referral process of children transitioning out of the EIP to CPSE.

## STATE CONTACT INFORMATION

For more information about the New York State Early Intervention Program and Public Health Law requirements, contact:

New York State DOH Early Intervention Program  
Room 287 Corning Tower Building  
Empire State Plaza  
Albany, New York 12237-0618  
Phone: 518-473-7016  
Fax: 518-486-1090  
E-mail: [eip@health.state.ny.us](mailto:eip@health.state.ny.us)  
[www.health.state.ny.us/nysdoh/eip/index.htm](http://www.health.state.ny.us/nysdoh/eip/index.htm)

For more information about the foster care system, contact:

New York Office of Children and Family Services  
[www.dfa.state.ny.us](http://www.dfa.state.ny.us)

## APPENDIX A - Definitions

**Basic Medical Evaluation** - LDSS is required to provide a comprehensive health assessment within 30 days of the child entering foster care that includes hearing and vision screening and an assessment to determine if the child requires services to address developmental delays.

**Case Manager** - individual responsible for "legal sign off" on all plans, all placements and all decisions regarding the child in the Foster Care System.

**Case Planner – 18 NYCRR Part 428** - assigned from the agency under contract that is responsible for the foster care placement. The case manager develops permanency plans after consultation and collaboration with the foster care agency caseworker and the birth parent. Although the contract agency case manager is the day-to-day contact and planner for the child, the contract agency is required to have the case manager sign off on all decisions/changes regarding the child's care in the Foster Care System.

**Child Protective Proceedings** - Proceedings brought by the local department of social services on behalf of children alleged to be abused and/or neglected. The standards and procedures described in Article 10 of the Family Court Act. One possible outcome of such proceedings is the child's placement into foster care/custody of the local commissioner of social services.

### Children at Risk

- **Defined by Early Intervention** as children at risk for developmental delay. The following risk criteria may be considered by the primary referral source in the decision to make a referral to the Early Intervention Program, for example:
  - No prenatal care;
  - Parental developmental disability or diagnosed serious and persistent mental illness;
  - Parental substance abuse, including alcohol or illicit drug abuse;
  - No well child care by 6 months of age or significant delay in immunizations; and/or,
  - Other risk criteria as identified by the primary referral source.
- **Defined by Social Services** as child who experiences parental neglect or abuse, or can not provide the child with a safe, permanent living arrangement.

**Due Process** - procedures designed to protect a person's rights. This includes requirements for confidentiality, consent, and processes to resolve disagreements and file complaints.

**Early Intervention Official /Designee (EIO/D)** – an appropriate municipal official designated by the chief executive officer of a municipality and an appropriate designee of such official. This is the responsible person for the Early Intervention Program in that municipality.

**Family Assessment** – An optional component of the evaluation process that is family-directed and designed to determine the resources, priorities, and concerns of the family related to enhancement of the child's development. Family assessment is voluntary on the part of the family.

**Individualized Family Service Plan (IFSP)** - a written plan for the child's and family's services in the Early Intervention Program that the family develops with a team of qualified personnel and the EIO/D.

**Interim Individualized Family Service Plan** - when the child and/or family are in apparent immediate need of early intervention services, a temporary IFSP can be developed to allow the child and family to receive early intervention services after the child has been referred to the program and before an evaluation is completed.

**LDSS District** - the local departments of social services - includes the NYC Administration for Children's Services and the 57 county departments of social services and the St. Regis Mohawk Tribe.

**Mediation** - a voluntary, non-adversarial process by which the parent of a child and the early intervention official or designee are assisted in the resolution of a dispute. In mediation, the parent and the Early Intervention Official try to reach an agreement with which both are satisfied.

**Municipality** - a county outside of the City of New York or the City of New York in the case of a county contained within the City of New York.

**Parent** - a parent by birth, adoption, or person in parental relation to the child and surrogate parent. Person in parental relation means:

- the child's legal guardian;
- the child's standby guardian;
- the child's custodian (a person who has assumed the charge and care of the child);
- person acting in the place of a parent (grandparent or stepparent with whom the child lives and who is legally responsible for the child's welfare).

**Parental Rights Terminated** - Unless parents have voluntarily surrendered guardianship and custody of the child or the Family Court or Surrogate's Court has terminated the parent's rights (i.e. involuntarily terminated the parent's guardianship and custody of the child), the parent still has rights and must be actively involved in services planning and decision-making.

**Service Coordinator** –

**Initial Service Coordinator** - assigned by the EIO/D, helps to work with the family with all the steps of the first Individualized Family Service Plan.

**Ongoing Service Coordinator** - selected by the parent; is responsible for coordinating the services provided by various personnel included in the IFSP; working with the family to enhance the child's development; monitoring the child's progress to identify changes needed in the plan; and, preparing and coordinating the six-month and annual review of the family service plan.

**Surrogate Parent** – a person who is appointed by the EIO/D to act in place of the parent when the parent(s) are not available to participate in making decisions about the child's involvement in the Early Intervention Program. The surrogate parent has the same rights and responsibilities as accorded to the parent by the Early Intervention Program and will represent the child in all matters related to the Early Intervention Program.

**Ward of the State** – a term used in the Early Intervention Program referring to a child whose custody and guardianship have been transferred to the local social services official pursuant to a voluntary surrender by the child's parent or by a family court or surrogate court in conjunction with the termination of the parental rights of the child's parent.

**APPENDIX B - Children's Eligibility Status Based on Diagnosed Conditions with High Probability**

**The following information is from  
NYS DOH EI Memorandum Document 99-2- Appendix A**

### **APPENDIX C - Required Early Intervention Primary Referral Sources**

EIP Primary Referral Sources under Public Health Law (PHL) are to refer a child less than three years of age who they suspect of having or being at risk of a developmental delay, to the local EI Official within two working days of identification. Parental consent is not required; however, parents may object to a referral. If the parent objects to the referral then the primary referral source must document the objection and make reasonable efforts to follow up with the parent within two months.

#### EIP Primary Referral Sources

Hospital

Child Health Care Providers

Local Health Facilities

Article 28 Clinics

Article 16 Clinics

Article 31 Clinics

Day Care programs

Early Childhood Direction Centers

School Districts

Social Service Districts

EI Service Providers

All qualified personnel under the EI law

## **APPENDIX D - Mandated Reporters of Child Abuse and Maltreatment**

Many, though not all, of the professionals who are required to report incidents of suspected child abuse and maltreatment (mandated reporters) are also required to make referrals for infants and toddlers suspected of having, or being at risk of, a developmental delay (primary referral sources). The persons indicated below are mandated to report when they have reasonable cause to suspect that a child has been abused or maltreated when the child, guardian, parent or other legal responsible party is before them in their official or professional capacity. Neither parental consent nor notification is necessary, and parental objection does not remove the obligation.

Mandated reporters of child abuse and maltreatment are required to report suspected incidents of abuse and maltreatment (of children up to age 18) to the NYS Child Abuse Hotline (1-800-635-1522). Two districts, Onondaga (315) 422-9701 and Monroe (585) 461-5690, maintain their own child abuse and maltreatment hotline numbers.

### **Mandated Reporters of Child Abuse & Maltreatment**

Physicians/Registered Physician Assistants	Providers of Family or Group Family Day Care
Surgeons	School Officials
Medical Examiners, Coroners	Social Services Workers
Dentists/Hygienists	Employees or Volunteers in a Residential Care Facility or Other Child Care or Foster Care Workers
Optometrists	Mental Health Professionals
Chiropractors	Substance Abuse Counselors
Osteopath	Alcoholism Counselors
Residents	Peace Officers
Psychologists	Police Officers
Interns	District Attorneys/Assistant District Attorneys
Podiatrists	Investigators employed in the office of a district attorney
Emergency Medical Technicians	Other law enforcement officials
Hospital personnel engaged in the admission, examination, care of treatment of persons	<b>Effective September 1, 2004</b>
Registered Nurses	Social Workers
Christian Science Practitioners	
Day Care Center Workers	

## **APPENDIX E - Definition of Medical Neglect**

A *parent* or other person legally responsible for the child must supply adequate medical, dental, optometrical or surgical care if financially able to do so or offered financial or other reasonable means to do so.

This includes:

- Seeking adequate treatment for conditions, which impair or threaten to impair the child's mental, emotional or physical condition;
- Following prescribed treatment for remedial care including psychiatric and psychological services;
- Obtaining preventive care such as postnatal check-ups, and immunizations for polio, mumps, measles, diphtheria and rubella.

The parent's failure to seek or follow adequate treatment or desire to select an unconventional form of treatment must be considered in light of:

- The seriousness of the child's conditions and risk of further harm to the child;
- The parent's awareness of the child's condition and risk of further harm to the child;
- Whether the parent has sought accredited medical opinion;
- The consensus of responsible medical authority regarding treatment;
- Whether the parent's failure to seek adequate treatment or select an unconventional form of treatment impairs the child physically or emotionally;
- Whether the parent fails to seek adequate treatment despite financial or other reasonable means to do so.

Article 10 of the Family Court Act authorizes intervention not only in life and death emergencies, but also in situations where a child is denied adequate medical, dental, optometrical, or surgical care due to the parent's or person legally responsible's failure to provide "...an acceptable course of medical treatment for their child in light of all the surrounding circumstances." The Court's inquiry should be whether the parents, once having sought accredited medical assistance, and having been made aware of the seriousness of their child's affliction, and the possibility of cure if a certain mode of treatment is undertaken have provided for their child a treatment which is recommended by their physician, and which has not been totally rejected by all responsible medical authority. In the Matter of Hofbauer, 47 N.Y. 2d 648, 393 N.E. 2d 1009, 419 N.Y.S. 2d 936 (1979).

The same test applies in cases in which a parent objects to medical treatment based on religious belief. The focus must be whether the parents have provided an acceptable course of medical treatment for their child in light of all the surrounding circumstances. A child who has been harmed or who is in imminent danger of harm, as a result of a parent's failure to supply adequate medical, dental, optometrical or surgical care, although financially able to do so or offered reasonable means to do so is a neglected child. In the Matter of Gregory S. et al, 85 Misc. 2d 845, 380 N.Y.S. 2d 620, (Fam. Ct., Kings Co. 1976)

## IMMEDIATE CONSIDERATIONS

- In the opinion of accredited medical professionals, what is the nature and extent of the child's condition?
- Did the parent seek accredited medical assistance for the child?
- What do responsible medical authorities prescribe as the recommended form of treatment? Identify authorities by name and address.
- What is the parent's explanation for this course of action? Have inadequate finances blocked parental ability to obtain treatment? Good note taking is essential. Use direct quotes.
- Has the child's condition been impaired or at imminent risk of impairment by parental actions or failures to act? Have the parents exercised a minimum degree of care of the child?

**APPENDIX F - Definition of Abuse and Maltreatment**

NEW YORK STATE CONSOLIDATED LAWS  
Social Services  
TITLE 6 CHILD PROTECTIVE SERVICES

Article 10 Family Court Act (FCA) 1012(e)

"Abused child" means a child less than eighteen years of age whose parent or other person legally responsible for his care

- (i) inflicts or allows to be inflicted upon such child physical injury by other than accidental means which causes or creates a substantial risk of death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ, or
- (ii) creates or allows to be created a substantial risk of physical injury to such child by other than accidental means which would be likely to cause death or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ, or
- (iii) commits, or allows to be committed an offense against such child defined in article one hundred thirty of the penal law; allows, permits or encourages such child to engage in any act described in sections 230.25, 230.30 and 230.32 of the penal law; commits any of the acts described in section 255.25 of the penal law; or allows such child to engage in acts or conduct described in article two hundred sixty-three of the penal law provided, however, that
  - (a) the corroboration requirements contained in the penal law and
  - (b) the age requirement for the application of article two hundred sixty-three of such law shall not apply to proceedings under this article.

Article 10 Act (FCA) 1012(f)

"Neglected child" means a child less than eighteen years of age

- (i) whose physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his parent or other person legally responsible for his care to exercise a minimum degree of care
  - (a) in supplying the child with adequate food, clothing, shelter or education in accordance with the provisions of part one of article sixty-five of the education law, or medical, dental, optometrical or surgical care, though financially able to do so or offered financial or other reasonable means to do so; or
  - (b) in providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or a substantial risk thereof, including the infliction of excessive corporal punishment; or by misusing a drug or drugs; or by misusing alcoholic beverages to the extent that he loses self-

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control of his actions; or by any other acts of a similarly serious nature requiring the aid of the court; provided, however, that where the respondent is voluntarily and regularly participating in a rehabilitative program, evidence that the respondent has repeatedly misused a drug or drugs or alcoholic beverages to the extent that he loses self-control of his actions shall not establish that the child is a neglected child in the absence of evidence establishing that the child's physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as set forth in

- (i) paragraph of this subdivision; or
- (ii) who has been abandoned, in accordance with the definition and other criteria set forth in subdivision five of section three hundred eighty-four-b of the social services law, by his parents or other person legally responsible for his care.

## **APPENDIX G - Referral of Children at Risk**

### Sec. 69-4.3(f) Referrals

Referrals of children at risk of having a disability shall be made based on the following medical/biological risk factors:

- (1) Medical/biological neonatal risk criteria, including:
  - birth weight less than 1501 grams
  - gestational age less than 33 weeks
  - central nervous system insult or abnormality (including neonatal seizures, intracranial hemorrhage, need for ventilator support for more than 48 hours, birth trauma)
  - congenital malformations
  - asphyxia (Apgar score of three or less at five minutes)
  - abnormalities in muscle tone, such as hyper- or hypotonicity
  - hyperbilirubinemia (> 20mg/dl)
  - hypoglycemia (serum glucose under 20 mg/dl)
  - growth deficiency/nutritional problems (*e.g.*, small for gestational age; significant feeding problem)
  - presence of Inborn Metabolic Disorder (IMD)
  - perinatally- or congenitally-transmitted infection (*e.g.*, HIV, hepatitis B, syphilis)
  - 10 or more days hospitalization in a Neonatal Intensive Care Unit (NICU)
  - maternal prenatal alcohol abuse
  - maternal prenatal abuse of illicit substances/prenatal exposure to move to new one therapeutic drugs with known potential developmental implications (*e.g.*, psychotropic medications, anticonvulsant, antineoplastic)
  - maternal PKU
  - suspected hearing impairment (*e.g.*, familial history of hearing impairment or loss; suspicion based on gross screening measures)
  - suspected vision impairment (suspicion based on gross screening measures)
  
- (2) Medical/biological post-neonatal and early childhood risk criteria, including:
  - parental or caregiver concern about developmental status
  - serious illness or traumatic injury with implications for central nervous system development and requiring hospitalization in a pediatric intensive care unit for ten or more days
  - elevated venous blood lead levels (above 19 mcg/dl)
  - growth deficiency/nutritional problems (*e.g.*, significant organic or inorganic failure-to-thrive, significant iron-deficiency anemia)

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chronicity of serous otitis media (continuous for a minimum of three months)  
HIV infection

The following risk criteria may be considered by the primary referral source in the decision to make a referral:

- (1) no prenatal care
- (2) parental developmental disability or diagnosed serious and persistent mental illness
- (3) parental substance abuse, including alcohol or illicit drug abuse
- (4) no well child care by 6 months of age or significant delay in immunizations; and/or
- (5) other risk criteria as identified by the primary referral source

## **APPENDIX H - Criteria for Eligibility for Preschool Special Education Programs and/or Services**

Part 200 of the Regulations of the Commissioner states, "Eligibility as a preschool student with a disability shall be based on the results of an individual evaluation which is provided in the student's native language, not dependent on a single procedure, and administered by a multidisciplinary team in accordance with all other requirements as described in section 200.4(b) and 200.16(c) of the regulations.

1. Commencing July 1, 1993, to be identified as having a disability, a preschool student shall either:

- (i) exhibit a significant delay or disability in one or more functional areas related to **cognitive, language and communicative, adaptive, socio-emotional or motor development** which adversely affects the student's ability to learn. Such delay or disability shall be documented by the results of the individual evaluation which includes but is not limited to information in all functional areas obtained from a structured observation of a student's performance and behavior, a parental interview and other individually administered assessment procedures, and, when reviewed in combination and compared to accepted milestones for child development, indicate:

- a. a 12-month delay in one or more functional area(s); or
- b. a 33 percent delay in one functional area or a 25 percent delay in each of two functional areas; or
- c. if appropriate standardized instruments are individually administered in the evaluation process, a score of 2.0 standard deviations below the mean in one functional area, or a score of 1.5 standard deviations below the mean in each of two functional areas; \* or

- (ii) meet the criteria set forth in paragraphs (1), (2), (3), (5), (9), (10), (12), or (13) of subdivision (zz) of this section.

\*Calculated on the basis of months

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**APPENDIX I - Office of Children and Family Services Commissioner Letter**

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New York State  
Office of  
Children & Family  
Services

May 27, 1999

Dear Commissioner:

George E. Pataki  
Governor

John A. Johnson  
Commissioner

The Office is sending this letter to clarify the authority of social services districts in regard to foster children who are participating in the Early Intervention Program for Infants and Toddlers with Disabilities (EI Program) administered by the New York State Department of Health (DOH). The Office was asked to issue this letter because questions were recently raised by social services districts and EI programs regarding what role social services officials could have in such cases. In particular, the issue of when a surrogate parent is appointed was identified.

Capital View Office Park  
52 Washington Street  
Rensselaer, NY 12144-2796

The EI program is a statewide mechanism which identifies infants and toddlers with disabling conditions and evaluates their needs for a range of early intervention services. The EI program also develops individualized family service plans to address such needs. The statutory authority for the EI program is set forth in Article 25 of the Public Health Law and implementing regulations are set forth in 18 NYCRR Part 69.

Foster children who otherwise satisfy the eligibility requirements for the EI program are entitled to benefit from this program. When a foster child is in receipt of early intervention services, the early intervention official must make every effort to protect the right of parents to make decisions about a child's receipt of early intervention services. Also, the early intervention official must facilitate the involvement of the parent of a foster child in early intervention services.

The situation may arise where the early intervention official determines that a person needs to be appointed to serve in the position of a surrogate parent for EI program purposes. A qualified surrogate parent shall be appointed by the EI official when the child is a ward of the State or when the child is not a ward of the State. A ward of the State is defined to mean a child whose custody and guardianship have been transferred to a social services official pursuant to a voluntary surrender or an involuntary termination of parental rights.

A surrogate parent shall also be appointed when: i) a child is not a ward of the State; ii) his or her parents are unavailable after reasonable efforts to facilitate their participation and iii) the child has no person or parent relation. A person in parent relation means:

- (1) the child's legal guardian;



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- (2) the child's standby guardian after their authority becomes effective pursuant to section 1726 of the Surrogate's Court Procedure Act;
- (3) the child's custodian; a person shall be regarded as the custodian of a child if he or she has assumed the charge and care of the child because the parents or legally appointed guardian of the minor have died, are imprisoned, are mentally ill, or have been committed to an institution, or because they have abandoned or deserted such child or are living outside the state or their whereabouts are unknown; or
- (4) persons acting in the place of a parent, such as a grandparent or stepparent with whom the child lives, as well as persons who are legally responsible for the child's welfare;
- (5) except, this term does not apply to a child who is a ward of the State, and does not include a foster parent.

A surrogate parent may be appointed voluntarily by the child's parent. In accordance with 18 NYCRR 169 - 4.16(e), the early intervention official must select a surrogate parent who is qualified and willing to serve and who:

- (1) has no interest that conflicts with the interests of the child;
- (2) has knowledge and skills that ensure adequate representation of the child;
- (3) if available and appropriate, is a relative who has an ongoing relationship with the child or a foster parent with whom the child resides;
- (4) is not an employee of any agency involved in the provision of early intervention or other services to the child, provided however that a person who otherwise qualifies to be a surrogate parent is not considered an employee solely because he or she is paid by a public agency to serve as a surrogate parent; and
- (5) has been selected, for any child who is a ward of the State or for any child whose parent is unavailable and who is in the care and custody of the local social services commissioner, in consultation with the local commissioner of social services or designee.

In accordance with both federal and State standards, a surrogate parent may not be the commissioner of the social services district because of the role of the social services district in the provision of services to the child. However, the social services district does play an integral role in the EI program. The duties and responsibilities include:

- a) The early intervention official must establish an agreement with the social services district to identify eligible or potentially eligible foster children. The early intervention official must consult with the social services district to determine the availability of the parent and, if the parent is not available, to identify a suitable surrogate parent.

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The regulations promulgated by DOH also reference procedural safeguards. The local social services district, the local commissioner of social services or his or her designee is authorized to have access to records collected, maintained or used for EI program purposes. The local commissioner of social services or his or her designee is afforded notice and a right to be heard at any mediation or hearing relating to early intervention services provided to a foster child. The local commissioner of social services is not afforded standing rights at such proceedings.

The social services district retains case management responsibility over its foster child. The social services district continues to be responsible for casework, programmatic and legal activities in regard to the foster child. As stated above, the local commissioner can not serve as the surrogate parent, although a foster parent may. The local commissioner does have rights relating to access to records relating to the foster child and to be heard at administrative proceedings involving the foster child.

Clearly, the social services district and the EI program have mutual interests. The experience of this Office and DOH has been that both parties can work cooperatively to serve children and families.

Please contact your OCFS Regional Office if you wish to discuss these issues or if you have any questions.

Sincerely,



William F. Baccaglini, Director  
Strategic Planning and Policy Development

cc: Donna Noyes, NYSDOH  
OCFS Regional Office Directors

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*"Project Interface, Policy & Procedure Manual," developed and produced by InterAgency Council of Mental Retardation & Developmental Disabilities Agencies, Inc.*

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## **I. Syndromes/Conditions**

### **Conditions**

#### **Cleft Palate—749.00**

##### Description:

Cleft palate is a congenital fissure in the median line of the palate (bony roof of the mouth) which may extend through the uvula, soft palate, and hard palate; cleft lip may or may not be involved. Clefts involving the palate and/or lip are classified several ways; classification systems differ in terms of anatomical references (e.g. the American Cleft Palate Association differentiates between clefts of the prepalate (lip and alveolar process) while Davis and Ritchie consider the position of the cleft relative to the alveolar process. Regardless of the specific classification system used, clefts may be unilateral, bilateral, complete or total and incomplete, partial or subtotal. One other type is called a submucous cleft. These are further defined below.

- Complete or total: cleft palate in which the cleft extends from the lip through the alveolar process, hard palate and soft palate.
- Incomplete, partial or subtotal: cleft palate in which the cleft can be limited to the lip, alveolar process, hard palate, or soft palate, or a combination of these structures.
- Bilateral: failure of the palate on the right and left sides to fuse to the nasal partition or septum.
- Unilateral: fusion of the palate to the vertical nasal septum only on one side.
- Submucous: condition in which the surface tissues of the hard or soft palate unite but the underlying bone or muscle tissues do not; also called occult cleft palate.

##### Effects/Prognosis:

Cleft palate is associated with feeding and swallowing problems, failure to thrive (poor growth), aspiration, recurrent ear infections and hypernasal, dysarticulate speech. Specific speech/language characteristics also include nasal emission of air during production of fricative sounds and delayed development of language skills. Undesirable facial distortions or mannerisms may also accompany speech.

#### **Extreme Prematurity**

**Less than 500 grams—765.01**

**500-749 grams—765.02**

**750-999 grams—765.03**

##### Description:

Infants weighing less than 1500 grams are referred to as very-low-birth-weight (VLBW) babies and comprise 1.15 % of all births in the U.S. For infants born with birth-weights below 2500 grams, the mortality rate rapidly increases with decreasing weight, and most of the infants weighing 1000 grams or less do not survive. The average length of hospital stay for infants weighing 1000 grams or less is 89 days, with shorter lengths of stay for those who do not survive.

#### Effects/Prognosis:

Outcomes for this population are variable. Very low birth weight babies are at increased risk for neurodevelopmental complications. Ten to fifteen percent of surviving VLBW infants are affected by major deficits including spastic motor dysfunction (cerebral palsy) and associated mental retardation. These deficits appear to result largely from two defined lesions: intraventricular hemorrhage (IVH) and periventricular leucomalacia (PVL). Grade III and IV IVH are associated with major deficits in 50 to 90% of survivors. Outcomes for PVL are correlated with outcomes for Grades III and IV IVH. Other complications in VLBW babies may include breathing problems (hyaline-membrane disease or respiratory distress syndrome), feeding difficulties, seizure disorders, hydrocephalus, retinopathy of prematurity (also called retrolental fibroplasia) and increased risk for serious or protracted illness. Other associated problems of prematurity include heart abnormalities, renal problems and vision and hearing problems. Re-hospitalization during the first year of life is not uncommon; 40% of VLBW infants have almost two hospitalizations with an average of 16 days in the hospital in the first year of life. The average number of physician visits is also higher than for infants of normal birth-weight, ranging from 14-16 visits (compared with 10 visits for normal birth-weight babies). The presence of a congenital anomaly or developmental delay was a determining factor in physician use. Longer term problems for these infants may include behavior problems at preschool age and decreased performance on standardized IQ tests.

### **Syndromes/Chromosomal Abnormalities**

#### **Angleman's Syndrome (syndromes affecting multiple systems)--759.89**

##### Description:

Angleman's Syndrome is a disorder characterized by severe mental retardation with marked delay in attaining motor milestones, episodes of inappropriate laughter and limited or absent speech. Other signs include ataxia and jerky arm movements, said to resemble a "puppet gait." Seizure activity is most severe at about age 4 years and may stop by age ten years. Decreased need for sleep between ages 2 and 6 years has also been reported.

##### Effects/Prognosis:

Severe difficulties with speech; most individuals communicate using alternate means (e.g. sign language). Receptively, simple commands may be understood. Most individuals become toilet trained by day and some by night. All require a supported living arrangement.

#### **CHARGE Association (multiple anomalies)--759.7**

##### Description:

CHARGE Association is an association of multiple congenital malformations including: absence of part of the eye or retina (coloboma), heart disease, nasal blockage (choanal atresia), retarded growth and development with mental retardation ranging from mild to profound, genital anomalies, ear anomalies and sensorineural hearing loss. Visual and auditory problems may further compromise cognitive function. Other findings may include, but are not limited to: a small jaw (micrognathia), cleft lip, cleft palate, multiple

cranial nerve abnormalities, facial palsy, feeding difficulties resulting from poor suck and velopharyngeal incompetence, kidney (renal) anomalies and growth hormone deficiency.

Effects/Prognosis:

Effects depend on the severity of the defects. In some cases, death occurs shortly after birth due to respiratory insufficiency or heart disease. In less severely involved individuals, most show some degree of mental deficiency and/or CNS defects, along with visual and auditory deficits. Feeding difficulties, facial palsy and sensorineural hearing loss are related to cranial nerve abnormalities.

**Down syndrome (trisomy 21 or 22,G)—758.0**

Description:

Down Syndrome is a chromosomal disorder including the following clinical features: hypotonia (decreased muscle tone), short stature, flat facial profile, epicanthal folds, upslanting eye slits, small ears, speckling of the iris, cardiac defects, duodenal atresia, atlantoaxial instability (enlargement of distance between first two neck vertebrae that leaves the individual susceptible to spinal cord compression and neurological involvement), thyroid disorders, hearing loss (may be conductive, mixed or sensorineural) and mental retardation. Other attributes include poor coordination and relatively slow physical growth in the first 8 years. Sleep-related upper airway obstruction has been reported in about one third of cases.

Effects/Prognosis:

Multi-system disorder with varying degrees of severity. The I.Q. range is reported to be between 25 and 50 with occasional individuals above 50. Varying degrees of hearing loss and speech impairment are also associated. Social performance is usually beyond expectations for mental age.

**Edwards' Syndrome (Trisomy 18, E3)—758.2**

Description:

Edwards' Syndrome is a chromosomal syndrome and the second most common multiple malformation syndrome, with an incidence of 1/3000 births. Clinical findings include clenched hands with overlapping fingers, rocker-bottom feet (rigid flat feet), short sternum, heart disease, severe mental retardation and failure to thrive (poor growth). Poor sucking capability contributes to failure to thrive and may necessitate nasogastric feeding. Other characteristics include hypertonicity (after the neonatal period) and diminished response to sound.

Effects/Prognosis:

Babies with this syndrome are described as feeble and have limited capacity for survival. Resuscitation is often performed at birth and episodes of apnea may occur in the neonatal period. Fifty percent die within the first week and many of those remaining die within the first twelve months. Five to ten percent survive the first year. These individuals are typically unable to walk independently and usually have a very limited expressive vocabulary (a few single words). Some older children with Trisomy 18 reportedly smile, laugh and interact with their families. All are reported to achieve some psychomotor maturation and to continue to learn.

### **Fetal Alcohol Syndrome—760.71**

#### Description:

Fetal Alcohol Syndrome (FAS) is a syndrome resulting from effects of maternal alcohol ingestion. Malformations are caused in the developing fetus. Clinical findings in FAS include pre-and postnatal growth retardation, mild to moderate microcephaly, cognitive deficits (usually mild to moderate in degree) and characteristic facial features including short eye slits (palpebral fissures) and a smooth indentation in the upper lip below the nose (philtrum). A heart murmur may be present, frequently disappearing by 1 year of age. Associated difficulties may include myopia, strabismus (cross eye/squint), hearing loss, dental malocclusion, eustachian tube dysfunction, articulation problems, language disorders, specific learning disabilities and attention deficit/hyperactivity disorder. Incidence figures show 1/300 babies show some effect of maternal ingestion of alcohol and more than 1/1000 show the full-blown syndrome.

#### Effects/Prognosis:

Individuals with FAS may appear similar to those with “failure to thrive.” They tend to be irritable as infants and hyperactive as young children. A diagnosis of mild mental retardation is frequently reported. In general, the severity of the maternal alcoholism and the extent and severity of the pattern of malformation are predictive of the ultimate prognosis. A follow up study of a group of adolescents and adults with FAS (average age 18 years) revealed academic functioning at a fourth grade level with difficulty in mathematics noted. Other common behavioral characteristics in this group included poor judgement, distractibility and difficulty recognizing social cues.

### **Fragile X Syndrome—759.83**

#### Description:

Fragile X Syndrome is also known as Martin-Bell syndrome, Marker X syndrome and Escalante syndrome. This is a genetic syndrome characterized by mental retardation ranging from mild to profound in males. Attention problems related to hyperactivity and autism are commonly seen. Other features include macrocephaly (abnormally large head) and macrosomia (large body size) in early childhood, thickening of the nasal bridge extending down to the tip of the nose, large ears, pale blue eyes, epicanthal folds (crescent-shaped folds of skin extending down from the side of the nose to the lower eye lid and partially covering the inner corner of the eye opening) and dental crowding. Hand flapping or biting and poor eye contact are also characteristic. A speech pattern called “cluttering” (rapid speech with some syllables omitted; may be difficult to understand) is also typical in higher functioning individuals. Occasional associated abnormalities may include submucous cleft palate and heart disease. In females, involvement tends to be mild; shyness, anxiety and panic attacks are reportedly seen.

#### Effects/Prognosis:

Effects are dependent on the degree of cognitive involvement and are more pronounced in males. Females typically show milder effects but do have educational difficulties.

### **Patau’s Syndrome (Trisomy 13, D1)—758.1**

#### Description:

Patau’s Syndrome is a chromosomal disorder with multi-system involvement with an estimated incidence of 1/8000 births. Clinical findings include microcephaly

(abnormally small head), incomplete development of the forebrain, severe mental retardation, clefting (lip and palate), hyperconvex nails and extra fingers or toes (polydactyly). Other characteristic abnormalities include: apneic spells in early infancy, deafness, visual deficits and heart disease in more than 50% of cases. Fewer than one child in five survives the first year of life. Advanced maternal age is a contributing factor in the occurrence of this syndrome.

Effects/Prognosis:

The average survival for children with this disorder is 2.5 days, with only 5% surviving the first 6 months. Survivors reportedly have severe mental defects and fail to thrive. Seizures are also typical.

**Prader-Willi Syndrome—759.81**

Description:

Prader-Willi Syndrome is also known as HHHO syndrome (Hypotonia-Hypogonadism-Hypomentia-Obesity syndrome). This is a genetic syndrome characterized by severe obesity, mental retardation (primarily in the mild to moderate range), poor muscle tone in infancy, short stature, small hands and feet, incomplete sexual development and behavior problems. Feeding problems are associated with this disorder in infancy and tube feeding is sometimes necessary. The hypotonia may cause respiratory problems as well. Failure to thrive may occur in early infancy; followed by a marked change with the development of an insatiable appetite. Onset of obesity may occur between age 6 months and 6 years, and is related to increased intake with reduced activity. At the same time, the hypotonia generally improves.

Three phases are identified: 1. infancy with decreased muscle tone (hypotonia) and failure to thrive; 2. childhood with features including almond-shaped eyes, small eye slit length, ravenous appetite (hyperphagia), cognitive deficits (ranging from mental retardation to learning disabilities and language impairments) and 3. young adulthood with increased severity of the childhood symptoms along with severe emotional and behavioral symptoms.

Effects/Prognosis:

Typical effects include mental retardation, most often in the mild to moderate range. Dietary management is key to prolonging life expectancy and reducing the chances of complications related to morbid obesity (e.g. cardiac complications). Speech problems (articulation) and hypernasal speech are noted. The individual may also persevere on favorite topics.

**II. Neuromuscular/Musculoskeletal Disorders**

**Congenital Muscular Dystrophy--359.0**

Description:

Congenital Muscular Dystrophy is a disease of the muscles, present at birth and manifested in the infant by low muscle tone. All muscular dystrophies are genetically determined; however the term congenital muscular dystrophy is used to encompass several distinct diseases with a common characteristic of severe involvement at birth.

Effects/Prognosis:

Infants often have contractures or arthrogyposis (multiple congenital contractures). Head control is poor. Facial muscles may be mildly involved. The prognosis is variable; the disease may progress or stay the same.

**Other Myopathies--359.8**

Description:

Myopathy is a disease or abnormal condition of striated muscle. They encompass a widely varied group of muscle diseases which are characterized by weakness in infancy or childhood. Other myopathies include endocrine myopathies (thyroid and steroid-induced), and metabolic myopathies (potassium-related periodic paralysis, malignant hyperthermia, glycogenoses, mitochondrial myopathies, lipid myopathies, and vitamin E deficiency myopathies).

Effects/Prognosis:

The effects and prognosis of other myopathies are variable, depending on the specific underlying disease.

**Werding-Hoffman Syndrome--335.0  
(Infantile Spinal Muscular Atrophy)**

Description:

Werding-Hoffman disease is the severe infantile form of spinal muscular atrophy. Spinal muscular atrophies are degenerative diseases of motor neurons that begin in fetal life and continue to be progressive in infancy and childhood.

Effects/Prognosis:

Affected infants have severe hypotonia and generalized weakness. Infants who are symptomatic at birth may have respiratory distress and are unable to feed. Most infants demonstrate symptoms by six months of age. The disease is progressive, and two thirds of severely involved infants die by two years of age.

**Spinal Cord Injury, NOS--952.9**

Description:

Spinal cord injury is a trauma to the spinal cord during the birth process or afterwards. Strong traction exerted during delivery may produce fracture and separation of the vertebrae. Transection of the cord may occur with or without vertebral fractures.

Effects/Prognosis:

Effects are variable, depending on the level and location of the lesion. There may be loss of sensation and paralysis below the level of injury. If the injury is severe, the infant may deteriorate rapidly to death within several hours. The course may be protracted with symptoms and signs appearing at birth or later in the first week; immobility and associated brachial plexus injuries may not be recognized for several days. Treatment of survivors of spinal cord injury is supportive, and they often remain permanently injured.

**Lobster Claw --755.58 (Hand)**

Description:

Lobster claw is a deformity of the extremities which causes deep clefts in the anterior part of the hand.

Effects/Prognosis:

Fingers may have various degrees of syndactyly (fingers joined together). The prognosis is good if only one extremity is involved. The prognosis may be poor if multiple congenital anomalies are present.

**Arthrogryposis--728.3**

Description:

Arthrogryposis is not a disease, but is a descriptive term that signifies multiple congenital contractures. Multiple contractures around the joints of the arms and legs result in wasting of the muscles and loss of function. Involvement ranges from mild deformities to deformities which make functioning almost impossible.

Effects/Prognosis:

The prognosis is variable, depending on the underlying cause.

**Phocomelia (absence of limb)--755.4**

Description:

Phocomelia is a congenital malformation where the proximal portions of the extremities are poorly developed or absent. The hands and feet may be attached to the trunk directly or by means of a poorly formed bone. In complete phocomelia, the hand or foot seems to spring directly from the trunk.

Effects/Prognosis:

Severe deformities of the extremities are often associated with other malformations incompatible with life. The prognosis is variable, depending on the severity of the involvement and associated defects.

**Spina Bifida w/o hydrocephalus (unspecified region)--741.90**

Description:

Spina Bifida is a disorder of early fetal development resulting in failure of the spinal cord to fuse properly. Spina bifida occulta is the least serious form, where there is an opening in the spine but no protrusion of membranes, nerves or spinal cord. This form does not usually cause loss of body function. Meningocele is the protrusion of the membrane-like coverings of the spinal cord and nerves. Myelomeningocele is the most severe type of spina bifida, where a sac containing spinal cord and nerves protrudes through the defect in the vertebrae.

Effects/Prognosis:

Depending on the location and severity of the spinal lesion, some or all of the functions made possible by a normal spinal cord and nerves may be decreased or absent below the spina bifida. Spina bifida may affect muscle control, movement and strength; sensation in the legs and lower body; urinary and bowel function; and neurological function.

**Spina Bifida with hydrocephalus (unspecified region)--741.00**

Description:

Spina bifida is a disorder of early fetal development resulting in failure of the spinal cord to fuse properly. Please refer to spina bifida w/o hydrocephalus, 741.90 for a definition of spina bifida. Hydrocephalus develops in some cases with spina bifida when the

normal flow of cerebrospinal fluid is blocked and becomes trapped within the spaces which lie inside the brain.

Effects/Prognosis:

Depending on the location and severity of the spinal lesion, some or all of the functions made possible by a normal spinal cord and nerves may be decreased or absent below the level of the spina bifida. The prognosis is variable, depending on the level of the lesion and how much of the spinal cord is involved. Hydrocephalus usually requires some form of neurological shunt placement to drain cerebrospinal fluid.

### **III. Central Nervous System (CNS) Abnormalities**

#### **Infantile Cerebral Palsy (Not otherwise specified-Nos)- - 343.9**

Description:

Cerebral palsy is a static encephalopathy (a generalized disorder of cerebral function) resulting from injury to the brain during its early (fetal, perinatal, and early childhood) stages of development. Cerebral palsy is a problem that involves the brain's ability to control the muscles; muscle and nerve function is essentially normal. Cerebral palsy is categorized by a description of the resultant motor handicap: *physiologic* classification identifies the major motor manifestation, *topographic* taxonomy indicates the involved extremities.

*Physiologic*- spasticity (muscle stiffness - hypertonia) present in 60% of all cases of CP  
dyskinesia (involuntary movements) present in approximately 20% of all cases of CP  
athetosis – slow writhing movements; choreoathetosis – abrupt and jerky movements; and  
dystonia – slow, rhythmic movements

ataxia (a broad based, lurching gait with primary balance difficulties) occurs by itself in about 1% of all CP.

*Topographic*-Diplegia – involvement of the trunk and all four extremities (the legs more so than the arms)

Hemiplegia – involvement of one side of the body only

Paraplegia – involvement of the legs only

Quadriplegia – involvement of both arms, both legs, the head, and the trunk

Monoplegia – involvement of one extremity

Triplegia – involvement of three extremities

Effects/ Prognosis:

Some children have barely detectable problems, while others have severe disabilities. Difficulties in mobility and communication are the major functional manifestations. There also may be associated problems with cognition, vision, and behavioral responses. Hearing impairment, seizures, constipation, and feeding difficulties can be accompanying health problems. Given the comprehensive care they require, children with CP can look forward to an average life span.

#### **Infantile Spasms without Intractable Epilepsy – 345.60 with intractable Epilepsy – 345.61**

Description:

Infantile Spasms are brief symmetrical contractions of the muscles of the neck, trunk, and extremities resulting in a jackknifing of the body. The character of the seizure depends on

whether the flexor or extensor muscles are predominately affected and the particular muscle groups involved. Infantile Spasms usually begin between the ages of 4 and 8 months and frequently emerge as a new development in a series of neurological abnormalities. Seizure activity typically occurs in clusters and tends to develop when the child is drowsy or immediately upon awakening. Eye movements and a pre- or post-spasm “cry” frequently accompany the seizure episodes. The most common EEG finding is hypsarhythmia; a continuous disorganized pattern of high voltage slow waves and spikes. ACTH and corticosteroids are the present treatment options, however, although there is often an improvement in the social interaction of the infant when spasms are controlled, there is no clear evidence that ACTH treatment improves the long-term outcome in terms of mental retardation. Infantile Spasms will subside in approximately one year in about 25% of the cases; and in two years in another 25% of the cases. The spasms may last 5 years or more and may be replaced by other types of seizure activity.

#### Effects/Prognosis:

Infantile Spasms are typically classified into two categories cryptogenic – normal pre-seizure health history, normal neurological examination and CT scan (10 –20% of Infantile Spasms are classified as cryptogenic and children with this subtype have a good prognosis).

Symptomatic – abnormal prenatal, postnatal, and postnatal factors including hypoxic-ischemic encephalopathy, congenital infections, inborn errors of metabolism, neurocutaneous syndromes, cytoarchitectural abnormalities, prematurity, Central Nervous System infections, and head traumas. Children with Symptomatic Infantile Spasms have an 80-90% risk of mild to severe mental retardation, depending on the severity of the neurological abnormalities before seizures appeared. Children with Infantile Spasms typically have delayed psychosocial development, and motor deficits such as spasticity and hypotonia. Microcephaly, cortical blindness and/or deafness, and a variety of other central nervous system (CNS) deficits are also present. Usually these problems are present in differing degrees prior to the onset Infantile Spasms. The presence or absence of certain risk factors can significantly alter the prognosis. Death occurs in approximately 29% of children with Infantile Spasms.

### **Encephalocele—742.0**

#### Description:

An encephalocele is a neural tube defect resulting in the herniation of the meninges and portions of the brain ( cerebral cortex, cerebellum, or portions of the brain stem) through a bony midline defect in the skull, most commonly in the occipital region. The neural tissue within an encephalocele is often abnormal. This condition is one of two major forms of dysraphism (defective fusion of parts that usually unite). The first form, a cranial meningocele, is less severe and consists of a meningeal sac only.

#### Effects/Prognosis:

The amount of compromised and deformed neural tissue determines the extent of cerebral dysfunction and the resultant disabilities. Even brain tissue not extending into the encephalocele may be structurally and functionally abnormal. The following problems are seen: hydrocephalus, microcephaly, motor delays with weakness and/or spasticity, ataxia, seizures, and visual problems.

## **Microcephalus—742.1**

### Description:

Microcephaly is a congenital abnormality of the central nervous system where the head circumference measures more than three standard deviations below the mean for age and sex. Microcephaly is divided into two main groups: primary or genetic and secondary or nongenetic. Primary microcephaly refers to a group of conditions that are associated with specific genetic syndromes (Down Syndrome, Cri-du-chat, Cornelia de Lange, Edward-18-trisomy, Rubinstein-Taybi, Smith-Lemli, Optiz); usually have no other malformations, and follow a mendelian pattern of inheritance (autosomal recessive, autosomal dominant). Secondary microcephaly results from a large number of noxious agents that may affect the fetus in utero or the infant during periods of rapid brain growth, particularly the first two years of life (radiation, drugs, congenital infections, meningitis, encephalitis, malnutrition, etc.). Occasionally, microcephaly is due to premature closure of the cranial sutures (craniosynostosis) but more often is the result of micrencephaly (a small brain).

### Effects/Prognosis:

The clinical manifestations and degree of central nervous system (CNS) dysfunction vary, but there is a correlation between the severity of the microcephaly and the degree of mental retardation. Almost 90% of children with microcephaly will have mental retardation. Milder decreases in head size have been associated with learning disabilities and language disorders.

## **Reduction deformities of the brain - - 742.2**

### **Holoprosencephaly**

#### Description:

An anterior midline defect which occurs during early fetal development (before 23 weeks gestation) of the midface and the forebrain. The consequences of this defect are varying degrees of malformations in midline facial development, and in brain development and function. The incidence is 6-12/100,000 live births and, although the cause is unknown, the condition is sometimes seen in conjunction with chromosomal anomalies and as an autosomal dominant and autosomal recessive defect. It is also seen in children of diabetic mothers and as a result of congenital infections (CMV, toxoplasmosis, and syphilis). Holoprosencephaly is categorized into 3 types according to clinical features:

1. Alobar – anophthalmia (congenital absence of one or both eyes), cyclopia, median and bilateral cleft lip and palate, microcephaly, severe mental deficiency, apneic spells, seizures, death;
2. Semilobar -- orbital hypotelorism, microphthalmia, coloboma, normal lip and palate, absence of philtrum, median cleft lip, flat nose, single-nostril nose, mild to severely mentally retarded;
- and 3. Lobar—normal face, single maxillary incisor, minimal handicap, mild to severely mentally retarded.

#### Effects/Prognosis:

The prognosis is dependent on the severity of the involvement; although most affected individuals die before 6 months of age. Mildly affected individuals may live to adulthood. The degree of facial malformation is usually predictive of brain malformation. This condition is considered the most devastating of the anterior midline defects. Complications may include endocrine abnormalities such as hypopituitarism, ACTH-adrenal axis failure, and diabetes insipidus. An anterior midline defect which

occurs during early fetal development (before 23 weeks gestation) of the midface and the forebrain. The consequences of this defect are varying degrees of malformations in midline facial development, and in brain development and function. The incidence is 6-12/100,000 live births and, although the cause is unknown, the condition is sometimes seen in conjunction with chromosomal anomalies and as an autosomal dominant and autosomal recessive defect. It is also seen in children of diabetic mothers and as a result of congenital infections (cytomegalovirus (CMV), toxoplasmosis and syphilis).

Effects/Prognosis:

The prognosis is dependent on the severity of the involvement; although most affected individuals die before 6 months of age. Mildly affected individuals may live to adulthood. The degree of facial malformation is usually predictive of brain malformation. This condition is considered the most devastating of the anterior midline defects. Complications may include endocrine abnormalities such as hypopituitarism, ACTH-adrenal axis failure, and diabetes insipidus.

**Lissencephaly**

Description:

A disorder of neuronal migration characterized by the absence of sulcation of the cerebral hemispheres resulting in a “smooth brain”. An insult before 12 weeks gestational age prevents successive waves of migrating neurons from reaching the cerebral cortex. This disorder is associated with various syndromes such as, *Miller-Dieker*, *Walker-Warburg*, *HARD+/-E Syndrome*. The following abnormalities are seen depending on the clinical subtype effecting the individual: open Sylvian fossa, absent or hypoplastic corpus callosum, large cavum septi pellucidi, small midline calcifications in the region of the third ventricle, microcephaly, high wrinkled forehead, small nose with anteverted nostrils, micrognathia, slanted palpebral fissures, low-set and/or posteriorly angulated auricles, late eruption of primary teeth, cryptorchidism, pilonidal sinus, polydactyly or syndactyly, and transverse palmar crease, cataracts, hypoplasia of optic nerve, microphthalmia, retinal dysplasia, hydrocephalus, congenital heart disease, duodenal atresia, renal agenesis.

Effects/Prognosis:

This condition may result in symptoms of failure to thrive, repeated aspiration pneumonia, hypotonia, or rigidity and opisthotonos, infantile spasms or other seizure activity, and severe mental retardation. Infants may exhibit brief visual fixation, smiling and nonspecific responses to stimulation. Developmental skills are minimal, and death usually occurs before 2 years of age.

**Congenital Hydrocephalus—742.3**

Description:

Hydrocephalus is a condition that results from impaired circulation and absorption of cerebral spinal fluid (CSF) or, in rare circumstances, from increased production by a choroid plexus papilloma within the intracranial cavity. Hydrocephalus can be the result of obstruction within the ventricular system (obstructive or noncommunicating hydrocephalus), or the result of obliteration or malfunction of the absorption sites, i.e., the subarachnoid cisterns or the arachnoid villa (nonobstructive or communicating

hydrocephalus). Hydrocephalus is termed “congenital” when it exists at birth, or “acquired” when it occurs as the result of injury to the brain after birth.

Effects/Prognosis:

When there is an excessive accumulation of CSF fluid in the ventricular system, the resultant pressure (intracranial pressure) leads to various symptoms depending on the age of the child, whether or not the cranial sutures have fused, and the treatment rendered. A frequent surgical treatment is the placement of a ventriculoperitoneal shunt, which diverts CSF from a lateral ventricle to the peritoneal cavity. Prognosis depends on the cause of the dilated ventricles as opposed to the size of the cortical mantle at the time of operative intervention. There is an increased risk of developmental disabilities including: a reduced mean intelligence quotient, particularly for performance tasks; abnormalities in memory function; visual problems such as strabismus, visual spatial abnormalities, visual field defects, optic atrophy and aggressive and delinquent behavior in some children.

**Cystic Periventricular Leukomalacia (CPVL)—348.8**

Description:

Periventricular Leukomalacia is a softening of the white matter of the brain in the area of the ventricles due to hypoxic ischemic injury. Intraventricular hemorrhage in the premature infant is often a factor in the development of necrosis of the periventricular white matter and the resulting cystic formation

Effects/Prognosis:

Babies with CPVL are at a high risk for developmental abnormalities. The degree of white matter necrosis influences the severity of the mental and/or motor problems that result. These abnormalities may include: spastic diplegia (legs more involved than arms); delays and qualitative problems in motor development; slow mental development; problems with hearing or vision; seizures; attention deficits; poor coordination or balance; problems with eye-hand coordination; learning disabilities and behavioral difficulties.

**Intraventricular Hemorrhage (grade IV) - -772.1**

Description:

Intraventricular Hemorrhage (IVH) is a bleeding in the tissue surrounding the ventricles of the brain, most common in premature infants. The incidence of IVH increases with decreasing birth weight, with 80-90% of the cases occurring between birth and the 3<sup>rd</sup> day of life. There are four levels of hemorrhage that have been defined as follows:

Grade I- bleeding is confined to the subependymal matrix

Grade II- indicates intraventricular bleeding

Grade III- includes grade II plus intraventricular dilatation

Grade IV- includes grade III plus intracerebral bleeding

Effects/Prognosis:

Babies with grade IV bleeds frequently develop serious ongoing neurological problems although the degree of neurological impairment may be related to a combination of factors such as the initial hypoxic or other insult, the hemorrhage itself, increased intracranial pressure, or the ventricular dilatation following the hemorrhage. Ten to fifteen % of low birth weight infants with IVH develop hydrocephalus. Leukomalacia and porencephalic cysts are other common complications. The following problems may

develop: fine and gross motor delays, cerebral palsy, vision and hearing impairments, and nongenetic.

### **Kernicterus—774.7**

#### Description:

Kernicterus is damage to particular parts of the brain (basal ganglia and brainstem nuclei) due to the accumulation of high levels of unconjugated bilirubin. An increase in bilirubin production or a decrease in bilirubin excretion or both will result in neonatal hyperbilirubinemia (bilirubin concentrations greater than 10 mg/dL in premature infants or 15mg/dL in fullterm infants). Excessive bilirubin accumulation from any cause can produce kernicterus, especially in the preterm or sick newborn. Some possible causes of neonatal hyperbilirubinemia are as follows: fetal-maternal blood group incompatibility, extravascular blood such as pulmonary or cerebral hemorrhage, polycythemia such as fetal to fetal transfusion, obstructive disorders such as a band or tumor, sepsis, intrauterine infection, respiratory distress syndrome, asphyxia, child of a diabetic mother.

#### Effects/Prognosis:

Hyperbilirubinemia is treated by early, frequent feedings, phototherapy, and exchange transfusions in an effort to prevent kernicterus. It is also vital to diagnose and treat the underlying cause of the hyperbilirubinemia to prevent or lessen the serious consequences of kernicterus. Kernicterus can result in following problems: opisthotonos, muscular rigidity, seizures, hypotonia, bilateral choreoathetosis with involuntary muscle spasm, extrapyramidal signs, mental deficiency, dysarthric speech, high frequency hearing loss, squints and defective upward movement of the eyes, ataxia. In mildly affected infants the syndrome may be characterized only by mild to moderate neuromuscular incoordination, partial deafness or minimal brain dysfunction occurring singly or in combination.

### **Multiple anomalies of brain (Nos.)—742.4**

#### **Congenital cerebral cyst**

(See below, True Porencephalic Cyst)

#### **Macrocephaly**

##### Description:

Macrocephaly is an occipitofrontal head circumference more than 2 standard deviations above the mean for age. The most frequent causes of macrocephaly are mass lesions (porencephalic cysts, tumors, subdural hematomas, etc.), megalencephaly, and hydrocephalus. Macrocephaly can be familial, or associated with a number of syndromes, and several storage diseases.

##### Effects/Prognosis:

Most significant degrees of macrocephaly are likely to indicate the presence of neurodevelopmental disorders. The effects and prognosis will depend on the underlying condition responsible for the increase in head circumference and the availability of prompt and effective treatment.

## **Megalencephaly**

### Description:

Megalencephaly is an abnormally large, oftentimes, malfunctioning brain.

### Effects/Prognosis:

Megalencephaly may be a familiar trait not associated with any other deficiencies, but usually is an indication of underlying medical problems such as epilepsy and other neurological conditions.

## **Porencephaly**

### Description:

Porencephaly is a fluid-filled cyst or cavity within the cerebrum. There are two types of porencephalic cysts:

- 1.) True Porencephalic Cysts: These are cysts that occur as a result of faulty embryonic neurodevelopment. They typically communicate with the ventricles, cerebral cortical surface, and/or subarachnoid space.

### Effects/Prognosis:

True Porencephalic Cysts are associated with more severe neurologic manifestations. Some of the possible manifestations are as follows: hypotonia, seizure disorder, developmental delay, mental retardation, mild to severe motor dysfunction, failure to thrive, optic atrophy, delayed limb growth, hydrocephalus, supranuclear bulbar palsy.

- 2.) Pseudoporencephalic Cysts typically arise after a well-defined destructive event (of normal brain tissue) such as vascular disruption or infection occurring late in fetal or early infantile life (intraventricular hemorrhage, periventricular leukomalacia, congenital infections). This event leads to a cavitation of the necrotic region and cyst formation within the parenchyma of the cerebral hemispheres. These cysts usually do not communicate with other structures, tend to be unilateral, and are typically not associated with other disorders.

### Effects/Prognosis:

Pseudoporencephalic Cysts are associated with hemiparesis and focal seizures in the first year of life. Prognosis is variable; some children develop only minor neurological signs and have normal intelligence.

## **IV. Hearing, Vision and Communication Disorders**

### **Retinopathy of Prematurity—362.21 (grades 4 and 5)**

#### Description:

Retinopathy of prematurity is also known as Terry disease. This is an eye disease that is a major cause of blindness. Retinopathy of prematurity (ROP) occurs primarily in premature infants and is more severe with decreasing birth weight. ROP results from abnormal development of the retina (the light sensitive lining of the eye) in premature babies. It occurs when abnormal blood vessels and scar tissue form at the edge of the normal retinal blood supply. The abnormal retina then has a damaging demand for oxygen.

ROP is a progressive disease that starts slowly, usually between the fourth to tenth week of life. Progression may be slow or rapid through Stages 1-5 or the disease may stop at the early stages and disappear completely. Not all premature infants develop ROP. The two critical factors for predicting who will develop ROP are birthweight less than 1500 grams and gestational age at birth less than 32 weeks. High oxygen levels may exacerbate ROP but do not cause the disease. Stages 4 and 5 reflect more severe involvement than the earlier stages.

Stage 4 ROP is caused by the scar tissue formed in Stages 1 through 3 pulling on the retina and causing it to separate from the wall of the eyeball. Stage 4 is subdivided, depending on the location of the detachment. In stage 4A, the detachment is partial and outside the macula (the area of central vision) and it may or may not affect the infant's vision. Stage 4B is characterized by partial detachment involving the macula. Stage 5 ROP involves a complete retinal detachment. Infants with Stage 5 ROP have essentially no useful vision in that eye.

Effects/Prognosis:

Stages 1 and 2 and Stage 3/mild require monitoring. Treatment is instituted at Stage 3/moderate or severe because these infants have a 50% chance of proceeding to Stage 4 or 5 and possible blindness. For Stage 4A, the chance for usable vision is relatively good if the retina reattaches. Stage 4B generally results in a more limited prospect for usable vision due to the macular involvement. Treatment options at Stage 5 involve surgery to attempt to reattach the retina. Some vision may be recovered by this surgery but the individual will most likely be legally blind in the involved eye.

**Conductive Hearing Loss (Nos.)—389.00**

Description:

Conductive hearing loss refers to hearing loss arising from failure of sound pressure to reach the cochlea (inner ear) through the normal air conduction channels (outer and/or middle ear). This type of hearing loss results from a problem in the outer and/or middle ear space and can range from mild to moderate-severe in degree. Causative factors range from fluid in the middle ear space to congenital malformations of the outer and/or middle ears. Depending on the cause, conductive hearing loss may fluctuate. In a conductive hearing loss, hearing sensitivity will be impaired via the air conduction (outer + middle + inner ear) pathway and normal via the bone conduction (inner ear) pathway.

Effects/Prognosis:

Effects of conductive hearing loss are dependent on the extent and duration of the hearing loss. For example, with a 30 dB HL (mild) hearing loss, 25-40% of the speech signal may be missed. This can result in difficulty hearing consonant sounds. The individual will generally have to expend greater energy to listen, resulting in fatigue. Typical symptoms include “not paying attention” and “daydreaming.” Depending on the cause, conductive hearing loss may be treated and cured through medical and/or surgical means. If the hearing loss cannot be resolved medically, amplification can be pursued if the individual is otologically cleared. Periodic audiological monitoring of hearing levels and middle ear function will be needed. Speech/language consultation may also be required.

It should be noted that the Early Intervention Program regulations (Section 69-4.3(e)(5)) specify that a hearing impairment qualifying as a diagnosed condition with a high probability of developmental delay is a diagnosed hearing loss that cannot be

corrected with treatment or surgery. Thus, for the purposes of this diagnostic category, only conductive hearing losses that are not amenable to resolution through medical or surgical means, are chronic in nature and/or have an impact on other areas of development, particularly speech/language/communication development, constitute diagnosed conditions with a high probability of developmental delay for the purposes of eligibility in the Early Intervention Program. Consistent with the regulatory language, an occasional or transient conductive hearing loss occurring in isolation, i.e., without concomitant delays in other developmental domains, would typically be managed through the child's primary medical care provider.

### **Sensorineural Hearing Loss (Nos.)—389.10**

#### Description:

Sensorineural hearing loss is a hearing loss resulting from a pathological condition in the inner ear (cochlea) or along the nerve pathway from the inner ear to the brainstem (cranial nerve 8); it may be cochlear or retrocochlear depending on the site of the lesion. Sensorineural hearing loss may range from mild to severe to profound in degree. Causes are varied and include congenital abnormality in the auditory nerve, damage to the cochlea (e.g. from certain antibiotics such as gentamycin) and diseases such as meningitis. Certain syndromes are associated with sensorineural hearing loss. High risk factors for sensorineural hearing loss include, but are not limited to: low birth weight (less than 1500 grams), anoxia, jaundice, cranial defects, congenital viral infections (e.g. rubella) and family history of hearing loss.

#### Effects/Prognosis:

Effects of sensorineural hearing loss depend on numerous factors, including the degree (extent) of hearing loss, age at onset of hearing loss, age at identification of the hearing loss and amplification (personal hearing aids, FM system) history. For example, an individual with a moderate (41-55 dB HL) sensorineural hearing loss can miss 75-80% of the speech signal without amplification. Effects on speech/language skills may include delayed or defective syntax, limited vocabulary, imperfect speech production and an atonal voice quality. With a severe hearing loss (71-90 dB HL), the individual may hear loud voices about one foot away from the ear. Optimal amplification will provide access to environmental sounds and to many speech sounds. Individuals with profound hearing loss (91 dB HL or more) may rely on vision as the primary avenue for communication and learning. If the loss is of prelingual (before speech development) onset, oral language and speech may not develop or will be severely delayed. Prognosis varies depending on multiple factors, including consistent amplification and intervention emphasizing development of language, speech and auditory skills. Regular audiological consultation to monitor hearing levels and amplification will be required.

### **Mixed Conductive and Sensorineural Hearing Loss—389.20**

#### Description:

Mixed hearing loss is a combination of conductive (outer and/or middle ear) and sensorineural (inner ear) hearing loss occurring simultaneously. The hearing loss may range from mild to severe to profound in degree.

Effects/Prognosis:

Effects of the hearing loss depend on numerous factors, described above. Management of the hearing loss will include medical consultation regarding the conductive (outer and/or middle ear) component and may include amplification to address the remaining hearing loss, once the individual is otologically cleared. Regular audiological consultation to monitor hearing levels, middle ear status and any amplification needs will be required. Speech/language consultation may also be required.

**Unspecified anomalies of the ear with hearing impairment—744.00**

Description:

Anomalies of the ear generally include external ear changes that make these syndromes easier to diagnose. The hearing loss may be congenital or slowly progressive. Syndromes include, but are not limited to: 1. atresia (closure) of the external auditory canal with conductive hearing loss; 2. ear malformations, persistent periauricular pits (depressions around the external ear), sinuses or nodules, and mixed hearing loss; 3. preauricular pits, persistent branchial (Gill) clefts or fistulas, and sensorineural hearing loss; 4. malformed low-set ears and conductive hearing loss; 5. small external ear, meatal (ear canal) atresia and conductive hearing loss; and 6. lop ears, small lower jaw, and hearing impairment of mixed type.

When a middle ear deformity is present, the stapes, which develops from different embryological origins than the malleus and incus, is usually involved.

Other structural lesions producing hearing impairment involving congenital inner ear anomalies have been described. These are: 1. The Michel type 2. The Mondini-Alexander type 3. The Bing-Siebenmann type 4. The Scheibe, or cochleo-saccular type (which is the most common type of congenital abnormality and accounts for 70% of cases) 5. The Siebenmann type and 6. Type VI exhibits microtia (abnormally small external ear) and atresia (absence or closure) of the external meatus (ear canal).

Effects/Prognosis:

Effects are variable and dependent on numerous factors including the extent of hearing loss. Otologic management will be required to address the medical aspects and audiological management will be required to maximize the use of the individual's residual hearing. Speech/language consultation may also be required.

**Dyspraxia Syndrome—315.40**

Description:

Dyspraxia is a less severe form of apraxia. Apraxia is defined as a disruption in the ability to transmit or express a motor response along a specific modality; involves disruption of voluntary or purposeful programming of muscular movements while involuntary movements remain intact; characterized by difficulty in articulation of speech, formation of letters in writing, or in movements of gesture and pantomime. In speech, a non-linguistic sensorimotor disorder of articulation characterized by impaired capacity to program the position of speech musculature and the sequencing of muscle movements (respiratory, laryngeal, oral) for the volitional production of phonemes. Synonymous terms include: oral, speech or verbal apraxia.

Effects/Prognosis:

Variable, depending on the severity of involvement. If severely affected, the treatment may include accessing other modes of communication, e.g. sign language or an augmentative communication device.

**Blindness, both eyes—369.00**

Description:

A person is termed blind when there is corrected visual acuity less than 20/200 in the better eye. It has been recommended that the definition of the term blind be restricted to the absence of light perception and that “visual impairment” and “low vision” be extended to describe persons with vision less than 20/200 but who retain light perception.

Effects/Prognosis:

Effects vary depending on such factors as the onset of blindness. Individuals with congenital blindness (born blind) may be developmentally delayed because the process of learning through the visual channel has been severely limited. Those with adventitious blindness (blindness occurring after birth) may be developmentally similar to others in their age group, depending on when the vision loss occurred. Blind infants may show delays in the areas of gross motor development related to the development of locomotion, in prehension (physical grasp) skills and in the development of attachment.

**Blindness, one eye, low vision other eye—369.10**

Description:

See definition for blindness, above. Low vision generally refers to severe visual impairment, not necessarily limited to distance vision. Low vision applies to all individuals who are unable to read the newspaper at a normal viewing distance, even with the aid of corrective lenses. The rate of visual handicaps is higher among individuals with multiple handicaps.

Effects/Prognosis:

Effects depend on the age of onset and amount of residual vision. Screening for potential visual abnormalities during infancy or early childhood is important as this is the optimal time for preventing or minimizing visual impairments. Signs of eye problems include frequent squinting or rubbing, of the eyes, lack of attention or irritability.

**Low vision both eyes (moderate to severe)—369.20**

Description:

See definition for low vision, above.

Effects/Prognosis:

See information under low vision (369.10), above.

**Optic nerve coloboma (bilateral), congenital—743.57**

Description:

Colobomata are areas of absent tissue, and are found where fetal clefts or fissures fail to close. In the eye, these may involve portions of the optic disc (the circular tip of the optic nerve).

Effects/Prognosis:

Involvement of the optic disc results in depressed central vision. Depending on the extent and location of the coloboma, there may be decreased visual acuity, nystagmus, strabismus, photophobia and a loss of visual fields. Treatment options include cosmetic contact lenses and/or sunglasses for colobomas of the iris. Optical aids may be helpful. When a coloboma of some part of the inner eye is suspected, visual fields measurement is suggested.

**Optic nerve coloboma (bilateral), acquired—377.23**

Description:

A coloboma is a defect in the eye, usually a fissure or cleft of the iris, ciliary body (thickened part of vascular tunic of the eye between the base of the iris and the anterior part of the choroid) or choroid (dark brown vascular coat of the eye between the sclera and the retina, extending from the ora serrata to the optic nerve; consists of blood vessels united by connective tissue). This condition may be acquired as a result of surgery.

Effects/Prognosis:

See above.

**Aniridia—743.45**

Description:

Aniridia is congenital absence of all or part of the iris. This defect is usually accompanied by photophobia, nystagmus and defective vision. Other associated conditions include glaucoma, progressive corneal degenerative changes, cataracts, macular hypoplasia and optic nerve hypoplasia. Transmission of this condition may be familial or sporadic. Sporadic aniridia is associated with Wilms tumor in 1/70 patients. In Aniridia-Wilms Tumor Association, abnormalities include moderate to severe mental deficiency in most patients, growth deficiency and microcephaly in one half of patients, craniofacial abnormalities, aniridia in most patients and Wilms tumor (a malignancy of the kidney) in one half of patients.

Effects/Prognosis:

It is estimated that one third of individuals with sporadic aniridia develop Wilms tumor, while 50% of those with combined aniridia, genitourinary anomalies, and mental retardation develop Wilms tumor. Effects of this disorder depend on the severity of the deficits. Associated eye abnormalities in addition to aniridia include congenital cataracts, nystagmus, ptosis (upper eyelid droops below its normal level) and blindness. With aniridia, there is usually decreased visual acuity (circa 20/200), photophobia, possible nystagmus, cataracts, displaced lens, and underdeveloped retina; visual fields are usually normal, unless glaucoma develops. Because the macula (the most sensitive part of the retina) doesn't fully develop ("macular hypoplasia"), reduced vision occurs. The macula is used for fine vision, such as for reading. Treatment strategies include pinhole contact lenses, tinted lenses and/or sunglasses, corrections for refractive errors, optical aids, lower illumination levels to control glare. Magnification may also be helpful. Long-term prognosis is poor if glaucoma develops.

## **Albinism—270.2**

### Description:

Albinism is a genetic absence of pigment of the skin, hair, and eyes, or eyes only, resulting from a metabolic defect. Visual impairment (refractive errors), strabismus (cross eye, squint), nystagmus (involuntary eye movements) and photosensitivity are common.

### Effects/Prognosis:

Due to absence of normal protection by melanin in the skin, individuals with albinism are predisposed to damage from ultraviolet light. They require use of sunscreen during exposure to sunlight. Eye abnormalities require ophthalmological evaluation and treatment/ correction based on the diagnosed condition.

## **Visual deprivation nystagmus—379.53**

### Description:

Nystagmus is an oscillatory motion of the eyes that may be congenital or acquired. Congenital nystagmus is pendular (back and forth movements are at roughly the same speed) at rest, with irregular jerking when the eyes are deviated to the sides. It is usually associated with poor visual acuity and is thought to be due to failure of development of visual fixation in infancy. Congenital nystagmus often accompanies congenital visual impairment (e.g. corneal opacity, cataract, albinism, aniridia, optic atrophy, chorioretinitis).

Nystagmus may also involve jerk-type movements, in which there is a rapid movement in one direction followed by a slower recovery movement in the opposite direction. The character of the oscillation may change in different positions of gaze, and there may be a null point at which the nystagmus is minimal. Patients with a null point tend to maximize their vision by assuming a head position in which the nystagmus is least marked. This head-turning to position eyes at a null point is a natural and effective means of improving vision.

Nystagmus is classified according to the position of the eyes when it occurs. Grade I nystagmus occurs only when the eyes are directed toward the fast component; Grade II occurs when the eyes are also in their primary position; Grade III occurs even when the eyes are directed toward the slow component.

### Effects/Prognosis:

Reduced visual acuity is caused by the inability to maintain a steady fixation. Head nodding often accompanies congenital nystagmus. Patients with a null point tend to maximize their vision by assuming a head position in which the nystagmus is least marked. This head-turning to position eyes at a null point is a natural and effective means of improving vision. Certain types of jerky nystagmus (usually Grade I types) show spontaneous improvement in childhood (up to age 10). This type may also be amenable to muscle surgery (essentially, a repositioning of muscles to take advantage of the point of least nystagmus, or position of relative rest).

Nystagmus reduces vision more at a distance than at close range. Therefore, a child with nystagmus may hold objects close to see them and will do better on near visual acuity tests than on a wall chart test. Educationally, children with nystagmus may tend to lose their place in beginning reading instruction and may be helped through the use of a typoscope (card with a rectangular hole, to view one word or line at a time), or an

underliner (card or strip of paper to “underline” the line being read). As children with nystagmus mature, they seem to need these support devices less often.

## **V. Psychiatric/Emotional/Behavioral Disorders**

### **Infantile Autism active state--299.00**

#### Description:

Infantile autism usually becomes evident before 30 months of age and is characterized by a qualitative impairment in verbal and nonverbal communication, imaginative activity, and reciprocal social interactions.

#### Effects/Prognosis:

The most notable symptoms and signs, consequences of impaired communication and social reciprocity, are nondeveloped or poorly developed verbal and nonverbal communication skills, abnormalities in speech patterns, impaired ability to sustain a conversation, and abnormal social play. Stereotypic body movements, a marked need for sameness, narrow interests, and preoccupation with parts of the body are also frequent. Eye contact is minimal or absent. If speech is present, echolalia, pronomial reversal and other idiosyncratic language forms may predominate. Prognosis is guarded. Some children, especially those with language may become marginally self sufficient. A better prognosis is associated with higher intelligence, functional speech, and less bizarre symptoms and behavior. Symptoms often may change as children grow older.

### **Pervasive Developmental Disorder (PDD) --299.80**

#### Description:

Pervasive developmental disorder includes autism as its major diagnostic entity; pervasive developmental disorder *not otherwise specified* refers to children who have autistic features but do not formally qualify for that diagnosis. Some children have a qualitative impairment in the development of reciprocal social interaction and verbal and nonverbal communication but do not have the quantity of symptoms necessary for a diagnosis of autism. These individuals may be diagnosed as having a schizoid personality disorder or Asperger syndrome, which generally refers to a higher functioning form of autism, although this distinction remains somewhat controversial.

#### Effects/Prognosis:

Pervasive developmental disorder is a pattern of atypical development that can coexist with mental retardation. Children may be somewhat socially aware, but appear to others to be peculiar and eccentric. Prognosis for these individuals would be similar to that of those children with autism who have higher intelligence and functional speech.

### **Prolonged Post Traumatic Stress Disorder--309.81**

#### Description:

Post traumatic stress disorder (PTSD) is a psychophysiological syndrome which may follow trauma, either episodic (as in a single extremely stressful event like rape, fire, flood), prolonged (wartime events/conditions) or cumulative so called "strain trauma," (ongoing child abuse, incest, neglect). The symptoms and behavioral manifestations vary with the developmental level of the child.

Effects/Prognosis:

Very young children may present with what appear to be developmental delays and/or behavior and anxiety disorders. Symptoms can be grouped as hyperarousal (anxiety states, especially separation anxiety, hyperactivity, sleep disturbances, hypervigilance), hypoarousal (numbness, inattention, difficulty concentrating, "withdrawn" behavior, avoidant/phobic behavior) and reexperiencing (repetitive reenacting play).

**Emotional Disturbance of Childhood (Unspecified)--313.9**

Description:

The categories of emotional disorder that apply to children include three that are specific to children--overanxious disorder, avoidant disorder of childhood, and separation anxiety disorder; and a number from the adult nosology--obsessive compulsive disorders, phobic disorders, somatoform disorders, and depressive disorders.

Effects/Prognosis:

The symptoms of emotional disorders in very young children are frequently not as well differentiated as they are in adults. As a result it is sometimes difficult to categorize an emotional disorder in a child because there is no predominant type of symptom that colors the clinical picture or appears to be specifically related to functional impairment. Many children with emotional disorders grow up to be healthy adults, with the likely exceptions of those with definite childhood diagnoses of obsessive-compulsive, severe separation anxiety, and severe depressive disorders.

**Attention Deficit/Hyperactivity Disorder--combined type--314.01**

Note: texts dated 1996 and after do not give separate definitions and descriptions for Attention Deficit Disorder (ADD) with and without hyperactivity. The current terminology describes a "predominately inattentive type" and a "predominately hyperactive/impulsive type" and a "combined type".

Description:

Children with attention deficit/hyperactivity disorder (ADHD) commonly exhibit elements of both inattention and hyperactivity-impulsivity in varying degrees and combinations.

Effects/Prognosis:

Characteristics of this disorder may include poor ability to attend to a task, heightened distractibility, motoric overactivity and impulsivity. Children with attention deficit hyperactivity disorder may have difficulty following instructions and sustaining attention, shift rapidly from one uncompleted activity to another, talk excessively, intrude on others, often seem not to listen to what is being said, lose items regularly, and often engage in physically dangerous activities without considering possible consequences. A program that gives structure to a child's environment decreases the effects of the handicap. Although hyperactivity may be short-lived, other symptoms of ADHD may persist into later life.

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