



Health Care Program for Children in Foster Care

Public Health Nurse

Standards of Practice Manual

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Preface

Acknowledgement

The Manual Revision Committee acknowledges the valuable assistance of Public Health Nurses statewide who contributed their research, professional experiences and best practices illuminated this document.

The purpose of this document is to provide assistance to any PHN working in Child Welfare and Juvenile Probation services for foster children and youth in out of home placement.

The Statewide Foster Care Subcommittee and Child Health and Disability Prevention Executive Committee have reviewed and approved this document.

Disclaimer

- The contents of this Resource Guideline are not all inclusive.
- The selected documents are meant to provide an overview of the Health Care Program for Children in Foster Care (HCPCFC) and to guide the reader to the other resources cited.
- The resources cited are from program policies and guidelines or published laws and regulations, etc. Where possible, primary sources (and web-links) are provided.
- Printouts of web pages are only current as of the date of download.
- For the latest edition, please refer back to the agency or program's website.

2013-2015

Manual Revision Contributors

BAY REGION
<i>CAROL BROWN, FOSTER CARE TASKFORCE</i>
<i>DEBRA PRICE, NAPA</i>
KATHY STEPHANIDES, SAN FRANCISCO
LENORA TORRES, SAN MATEO
ROBERTA L BRESLER-SULLIVAN, SOLANO
<i>LINO BANADOS, ALAMEDA</i>
<i>NITA LAGLEVA-GIBSON, MARIN</i>
<i>TAMMY VO, SANTA CLARA</i>

CENTRAL REGION
<i>ALOISE HAMEL, STANISLAUS</i>
LEO MARTINEZ, MERCED
LUPE WADE, FRESNO
JULIE SLAUGHTER, FRESNO
<i>PAT OLIVER, KINGS</i>
<i>SUSAN RUTOWSKI, FRESNO</i>
<i>VIRGINIA MCLAIN, STANISLAUS</i>

NORTH REGION
<i>AMY THURMAN, GLENN</i>
<i>JOHN SPRINGER, SHASTA</i>
<i>MARCIE CAYWOOD, CALAVERAS</i>
MELISSA STILES, TRINITY
NANCY SCHIFLET, SHASTA
KAREN L. KRUMENACKER, HUMBOLDT

SOUTH REGION
JULIA WOOD, LOS ANGELES
<i>MONETTE ANTONIO-MCCULLOUGH, LOS ANGELES</i>
<i>ANITA SECOR, SAN DIEGO</i>
<i>NAHID RAZAGHI, ORANGE</i>
<i>JUDY COHEN, SAN BERNADINO</i>
CRAIG DEMERS, RIVERSIDE
ETHLYN OBLAND, SAN BERNARDINO
SCHENELL FULMORE, LOS ANGELES
SUSAN HERNANDEZ, SAN BERNARDINO

STATE
<i>FLOREIDA QUIAOIT, DHCS-SYSTEMS OF CARE</i>
KAREN TRACY, DHCS-SYSTEMS OF CARE
<i>THERESA SANCHEZ , DHCS-SYSTEMS OF CARE</i>

This manual could not have been completed without the commitment, dedication, and loyalty of the committee members.
The authors of this manual are in bold italics.

Section 1-----Introduction

Welcome

The HCPCFC Standards of Practice Resource Guide was developed to explain the role and activities of the Public Health Nurse (PHN) working within Child Welfare and Juvenile Probation Services. This resource guide provides the new and practicing PHN with practical information needed to help *children in out of home placement* (foster children in the child welfare system and juvenile probation program) achieve best health outcomes while working in collaboration with the Child Welfare and Juvenile Probation Services. The role and activities of the PHN are explained throughout the resource guide to identify skills and interventions in addressing complex health needs of foster children.

Foster children typically have higher rates of serious health, emotional, behavioral, and developmental problems compared with other children from the same socio-economic background. These foster children have tremendous need for access to health care services for evaluation and treatment of complex health problems. The PHN is a key team member in a multi-disciplinary setting who works collaboratively with case workers, health care providers and substitute care providers (SCPs) to coordinate comprehensive health care services for foster children.

The PHN provides medical (health care) consultation and health care resource guidance to case workers as well as foster parents to address the health needs of foster children. The PHN also navigates the health care system to provide appropriate referrals and continuity of care for children in out of home placement. Our goal at HCPCFC is to serve every foster child with compassion. It is indeed a privilege for the PHN to be part of cohesive team and to express passion of caring to impact the life of a child in foster care.

The HCPCFC Standards of Practice Resource Guide contains general information and an overview of the role and activities of the PHN. It is highly recommended that the PHN check with their local Public Health, Child Welfare or Juvenile Probation Agencies regarding the appropriate use of the HCPCFC Standards of Practice Resource Guide. At this critical period, the PHN can find opportunities to promote best health outcomes for foster children through anticipatory guidance. The PHN provides invaluable health services to meet the health care needs of foster children during the time of crisis

Vision, Mission, Values and Belief Statements

HCPCFC Vision

To promote excellence in health outcomes for children in out-of-home placement

HCPCFC Mission

To ensure all children in out-of-home placement receive comprehensive health care services that address their unique and complex health needs

HCPCFC Values and Beliefs

- Advocate for foster children's health equality
- Collaborate with all community members serving foster children
- Compassionate continuity of care for foster children
- Fostering the professional development of HCPCFC members by increasing awareness of foster care legislation and policy
- Provide Nursing excellence and professionalism to the foster care community
- Seek evidence-based practices for provision of health services to children in foster care
- Serve as a repository of health knowledge for children in foster care

Section 2 ----- Program's History

Background

In 1998 the Foster Care Children's Task Force published a report highlighting the fact that foster children have serious health, emotional and developmental problems. The task force recommended a system of health care for children in foster care that would improve coordination and delivery of services in counties through the utilization of PHNs. As a result, [Assembly Bill 1111](#) (Chapter 147, Statutes of 1999) enacted the [Welfare and Institutions Code \(W&IC\) Section 16501.3](#) to establish the Health Care Program for Children in Foster Care (HCPCFC).

The HCPCFC was implemented by local Child Health and Disability Prevention (CHDP) programs to serve foster care children in their county by means of an interdepartmental Memorandum of Understanding (MOU) between the local child welfare service agency, probation department and public health department.

[Public Law \(PL\) 110-351](#), the federal Fostering Connections to Success and Increasing Adoptions Act of 2008, amended section 422 (b)(15)(A) of the Social Security Act to require states to develop a plan for ongoing oversight and coordination of health care services for children in foster care. The plan must be developed in coordination with the [State Title XIX](#) (Medicaid) agency and in consultation with pediatricians and other experts in health care and experts in and recipients of child welfare services.

This "Health Care Oversight and Coordination Plan:" (a) supports current efforts to determine and meet the health care needs of children and youth in foster care;(b) represents a coordinated strategy to identify and respond to their health, mental health and oral health needs and (c) supports oversight and coordination of health related services. The HCPCFC is the nexus for California's Health Care Oversight and Coordination Plan.

Children and adolescents in foster care are categorically eligible for Medi-Cal. The CHDP program administers the health assessment and immunization component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for Medicaid-eligible children and adolescents. The CHDP HCPCFC PHNs through administrative case consultation assure that children and youth in foster care receive all medically necessary health care pursuant to the State Plan and the EPSDT benefit.

Overview

The HCPCFC is a PHN program located in county child welfare service agencies and probation departments to provide PHN expertise in meeting the medical, oral health, mental and developmental needs of children and youth in foster care. *The local CHDP program is administratively responsible for the HCPCFC.* This includes the management of the required interdepartmental MOU with the local child welfare service agency, probation and health departments.

The goals and objectives of the HCPCFC are common to the health, welfare, and probation departments and are implemented through close collaboration and cooperation among this multi-disciplinary, interdepartmental team. The program has established a process through which PHNs consult and collaborate with the foster care team to promote access to comprehensive preventive health and specialty services. Through the HCPCFC, PHNs under the supervision of a supervising public health nurse (SPHN) provide the following services in consultation and collaboration with social workers (SWs) and probation officers (POs) both will hereby be known as the case managers:

- Advocate for the health care needs of the child/youth
- Provide medical case planning and coordination as they ensure the child/youth has a CHDP primary care provider (medical home)
- Assist foster parents in obtaining timely comprehensive assessments:
- Participate with the assessment provider or center in developing a health care plan for children.

- Expedite timely referrals for medical, dental and mental health services (MHSs).
- Follow children placed out of county to assure access to needed services.
- Serve as a resource to facilitate referrals to early intervention providers, specialty providers, dentists, mental health providers and other community programs
- Update the Health Education Passport (HEP) as required by law
- Medical Education
- Interpret medical reports for case workers and the courts
- Educate the case manager, judges, foster care providers, school nurses and others about the health care needs of the child.

The CHDP program, under the direction of the Systems of Care Division (SCD), works with community programs and agencies to identify the major obstacles children in foster care face in gaining access to coordinated, multidimensional services.

Legislative Authority

The State Budget Act of 1999 appropriated State General Funds to the California Department of Social Services (CDSS) for the purpose of increasing the use of PHNs in meeting the health care needs of children in foster care.

The enabling legislation for the HCPCFC is Assembly Bill 1111.

This legislation defined the components of the program and added to the Welfare and Institutions Code, Section 16501.3 (a) through (e).

This section was amended in 2009 to mandate the implementation of the HCPCFC in each county.

Funding Description

Caseload data for children and probation youth in foster care from the Child Welfare System/Case Management System (CWS/CMS), maintained by the CDSS form the basis for each CHDP local program's fiscal year funding from the annual state appropriation for HCPCFC.

The source of funds for the HCPCFC Administrative Budget is State General Funds match with up to 75 percent Federal Funds (XIX).

The source of funds for the optional CHDP Foster Care Administrative Budget County/City Match is county/city funds match with up to 75 percent Federal Funds (XIX). Funding for county/city HCPCFC administrative and operational costs is based on budgets prepared by the local CHDP program and approved by the SCD. PHN and Supervising PHN Personnel, Operating and Internal Indirect costs are the budget categories.

Child Health and Disability Prevention Program Overview

The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, psychosocial evaluation, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

The CHDP program oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

In July 2003, the CHDP program began the using the "CHDP Gateway, "an automated pre-enrollment process for non Medi-Cal, uninsured children. The CHDP Gateway serves as the entry point for these children to enroll in ongoing health care coverage through Medi-Cal. The CHDP Gateway is based on federal law found in Titles XIX and XXI of the Social Security Act that allows states to establish presumptive eligibility programs for children/youth.

The CHDP Program is operated at the local level by local health departments for each county and three cities. *Local CHDP programs are responsible for oversight of the HCPCFC.*

Since the HCPCFC is a program within the CHDP program, the required administrative activities of budget preparation and management, nursing supervision, and implementation of the HCPCFC MOU are the responsibility of the CHDP program. Collaboration among the local health, welfare, and probation departments in the development and implementation of the MOU is recognized as being fundamental to the success of the HCPCFC.

Program Overview References

CHDP Program Letter 99-6 (October 21, 1999)

The following link is the CHDP Program Letter that discusses the establishment of the Health Care Program for Children in Foster Care.

<http://www.dhcs.ca.gov/services/chdp/Documents/Letters/chdpp19906.pdf>

(Please note: This is a large file and will take some time to download.)

Suggested Areas of Responsibility for Child Health and Disability Prevention (CHDP) Public Health Nurses (PHNs) and Child Welfare Service (CWS) Agency Social Workers and Probation Officers in the Health Care Program For Children In Foster Care (HCPCFC)

County/City:

Effective Dates:

Service Provided	Local CHDP Responsibilities Foster Care PHN	Local Child Welfare Service Agency Responsibilities Social Worker/Probation Officer
Location	<ul style="list-style-type: none"> • PHN will be located in the CWS agency with accessibility to all team members. 	<ul style="list-style-type: none"> • PHN will be located in the CWS agency with accessibility to all team members servicing children in foster care, including any PHNs currently working in CWS.
Supervision	<ul style="list-style-type: none"> • PHN will be supervised by supervising PHN in the local CHDP Program with input from CWS agency staff. 	<ul style="list-style-type: none"> • CWS agency/Supervising Probation Officer will provide input to the supervising PHN.
Accessing Resources	<ul style="list-style-type: none"> • PHN will identify health care providers in the community. • PHN will evaluate the adequacy, accessibility and availability of the referral network for health care services and collaborate with CHDP staff to identify and recruit additional qualified providers. • PHN will serve as a resource to facilitate (e.g., assist in scheduling appointments, arranging transportation, etc.) referrals to early intervention providers, specialty providers, dentists, mental health providers, California Children Services (CCS) and other community programs. • PHN will assist PHNs in the child's county of residence to identify and access resources to address the health care needs of children placed out-of -county. 	<ul style="list-style-type: none"> • CWS agency Social Worker/Probation Officer will work with PHN to ensure that all children in foster care are referred for health services appropriate to age and health status on a timely basis. • CWS agency Social Worker/Probation Officer will work with the substitute care provider (Foster Parent) and the PHN to identify an appropriate health care provider for the child. • CWS agency Social Worker/Probation Officer will work with the PHN to ensure that children placed out-of-county have access to health services appropriate to age and health status.

County/City:

Effective Dates:

Service Provided	Local CHDP Responsibilities Foster Care PHN	Local Child Welfare Service Agency Responsibilities Social Worker/Probation Officer
Health Care Planning and Coordination	<ul style="list-style-type: none"> • PHN will interpret health care reports for social worker/probation officers and others as needed. • PHN will develop a health plan for each child expected to remain in foster care. • PHN will work with substitute care provider to ensure that the child's Health and Education Passport (HEP) or its equivalent is updated. • PHN will assist substitute care providers in obtaining timely comprehensive assessments. • PHN will expedite timely referrals for medical, dental, developmental, and mental health services. • PHN will assist social worker/probation officer in obtaining additional services necessary to educate and/or support the foster caregiver in providing for the special health care needs, including but not limited to Early and Periodic Screening, Diagnosis, and Treatment Supplemental Services (EPSDT-SS). • PHN will obtain and provide health care documentation when necessary to support the request for health care services. • PHN will collaborate with social worker/probation officer, biological parent when possible and substitute care provider to ensure that necessary medical/health care information is available to those persons responsible for providing healthcare for the child, including a copy of the HEP to the substitute care provider. • PHN will assist social worker/probation officer to assess the suitability of the foster care placement in light of the health care needs of the child. • PHN will collaborate with the social worker/probation officer and substitute care provider to develop a system of tracking and follow-up on changes in the health care status of the child, service needs, effectiveness of services provided, etc. • PHN will review child's health plan with social worker/probation officer as needed and at least every six months. 	<ul style="list-style-type: none"> • Child's Social Worker/Probation Officer will collaborate with PHN to develop a health plan which identifies the health care needs and service priorities for each child expected to remain in foster care for 6 months or longer. • Social Worker/Probation Officer or designee will incorporate the health plan into the child's case record. • Social Worker/Probation Officer will assemble and provide health care documentation to the court when necessary to support the request for health care services. • Social Worker/Probation Officer will collaborate to complete and keep current the child's HEP or its equivalent and provide a copy of the HEP to the substitute care provider. • Social Worker/Probation Officer will consult with the PHN to assess the suitability of the foster care placement in light of the health care needs of the child. • Social Worker/Probation Officer will collaborate with the PHN and substitute care provider to develop a system of tracking and follow-up on changes in the health care status of the child, service needs, effectiveness of services provided, etc. • Social Worker/Probation Officer will review child's health plan with PHN at least every six months and before every court hearing. Relevant information will be incorporated into the HEP and court report.

County/City:

Effective Dates:

Service Provided	Local CHDP Responsibilities Foster Care PHN	Local Child Welfare Service Agency Responsibilities Social Worker/Probation Officer
Training/Orientation	<ul style="list-style-type: none"> • PHN will participate in developing and providing educational programs for health care providers to increase community awareness of and interest in the special health care needs of children in foster care. • PHN will educate social workers, juvenile court staff, substitute care providers, school nurses and others about the health care needs of children in foster care. 	<ul style="list-style-type: none"> • CWS agency staff/Probation Officers will provide input to PHN in developing curriculum for training others about health care needs of children in foster care. • CWS agency staff/Probation Officers will collaborate with PHNs in educating juvenile court staff, substitute care providers, and others about the health care needs of children in foster care. • CWS agency personnel will arrange for PHN access to the Child Welfare Services/Case Management System (CWS/CMS) system and provide training in its use.
Policy/Procedure Development	<ul style="list-style-type: none"> • PHN will provide program consultation to CDSS/ Probation Departments in the development and implementation of the EPSDT/CHDP Program policies related to the Health Care Program for Children in Foster Care. • PHN will participate in multi-disciplinary meetings for review of health-related issues. 	<ul style="list-style-type: none"> • CWS agency staff/Probation Officers will include the PHN in team meetings and provide orientation to social services and consultation on CWS/CMS.
Transition from Foster Care	<ul style="list-style-type: none"> • PHN will provide assistance to the Social Worker/Probation Officer and the child leaving foster care on the availability of options of health care coverage and community resources to meet the health care needs upon emancipation. 	<ul style="list-style-type: none"> • CWS agency staff/Probation Officers will collaborate with PHN to assure person leaving foster care supervision is aware and connected to resources for independent living.

County/City:

Effective Dates:

Service Provided	Local CHDP Responsibilities Foster Care PHN	Local Child Welfare Service Agency Responsibilities Social Worker/Probation Officer
Quality Assurance	<ul style="list-style-type: none"> • PHN will conduct joint reviews of case records for documentation of health care services with CWS agency/Probation Department. • PHN will work with CWS agency/Probation Department to develop a plan for evaluating the process and impact of the addition of the PHN component to the foster care team. • PHN will establish baseline data for evaluating health care services provided to children in foster care. 	<ul style="list-style-type: none"> • CWS agency staff/Probation Officers will conduct joint reviews of case records for documentation of health care services. • CWS agency/Probation Department will work with PHN to develop a plan for evaluating the process and impact of the addition of the PHN component to the foster care team. • CWS agency/Probation Officers will collaborate and assist PHN in gathering data.

This Memorandum of Understanding is in effect from July 1, 20__ through June 30, 20__ unless revised by mutual agreement. In the event that changes in Federal or State requirements impact the current Memorandum of Understanding, the local health department, social services department, and probation department agree to renegotiate the pertinent section within 90 days of receiving new instructions from the State.

Public Health Director or Child Health and Disability Prevention Program Director

Date

County Social Services Director or County Child Welfare Service Agency Director

Date

Chief Probation Officer

Date

Sample Scope of Work

<http://www.dhcs.ca.gov/services/chdp/Documents/Letters/chdppl9906.pdf>

(See enclosure 3 in program letter. Please note: This is a large file and will take some time to download)

Sample PHN Duty Statement

<http://www.dhcs.ca.gov/services/chdp/Documents/Letters/chdppl9906.pdf>

(See enclosure 5b in program letter. Please note: This is a large file and will take some time to download)

All County Information Notice I-55-99 (September 2, 1999)

“New Foster Care PHN Program in County Welfare Departments”:

http://www.dss.cahwnet.gov/getinfo/acin99/I-55_99.pdf

All County Letter 99-108 (December 21, 1999)

“Instructions Regarding Local MOU for HCPCFC”

<http://www.dss.cahwnet.gov/getinfo/acl99/99-108.PDF>

Section 3-----Role and Guidelines of the HCPCFC PHN

Role of the PHN in the HCPCFC

The primary role of the PHN is to be a health care consultant to:

- Collaborate with the child's case manager, SW and PO.
- Find access to comprehensive health care services.
- Coordinate primary and specialty care needs in a timely manner.
- Promote quality and cost effective health care services.

The PHN in the HCPCFC do not provide direct patient care, only those nursing interventions or activities that are covered under Title XIX

Examples of activities of the HCPCFC PHN include:

- Participates with the SW in home, office, school or hospital visit to collect and evaluate health information in order to make the appropriate recommendations and referrals.
- Coordinates health services by making referrals to the appropriate community agencies such as: CHDP providers, California Children's Services (CCS), mental health clinics, Regional Centers, specialty providers, dental providers and other community resources.
- The PHN does assess the health care status of these children based on the data received from:
 - Child's SW
 - Caregivers
 - Medical Records
 - Home, Hospital, and Office visits
 - Regional Centers
 - Community Agencies
- Performs case review to identify the needs for services

- Analyzes collected assessment data to determine appropriate health care needs based
- Medical / Mental Health Providers
- Assessment finding with SW,
- Make conjoint decision with multidisciplinary team members: SW, Regional Center Worker, Foster Care Family Agency Worker and Medical/Mental Health Providers.
- Establish appropriate recommendations based on the collected data.
- Identify and search for appropriate health care services and community resources.
- Participate in multidisciplinary team approach to ensure that all the healthcare needs of foster children are met.
- Collaborate with community agencies and health care programs to maintain continuity of care.
- Collaborate with caregivers, multi-disciplinary team members and community agencies to facilitate the implementation of the health care plan.
- Update the HEP to maintain current medical information.
- Evaluate the health status of the children in the foster care system by:
 - Reviewing collected medical data.
 - Actively reviewing and updating the HEP based on medical information from providers
- Participating in case conferences such as Team Decision Making (TDM) Child and Family Team (CFT) or Multi-Disciplinary Team (MDT) meetings to ensure continuity of care

Continuity of care

A critical component of *quality* health care is the *continuity* of that care. Children in foster care are at an increased risk of discontinuity of health care as frequent change in their out of home placement is a common occurrence. In some cases a child may

change placements multiple times within a year. Along with the obvious challenges and adjustments of placement changes, there is often a change in primary care provider.

Children in foster care are a medically vulnerable population and are disproportionately high users of both medical and mental health care. These children have often lived in poverty and have a high prevalence of chronic conditions, and a history of inadequate or absent medical care.¹

The HCPCFC PHN brings a complementary skill set that contributes to the team's overall objective of achieving the desired health care outcomes.

As a member of a multidisciplinary foster care team, the HCPCFC PHN will promote continuity of care through the following interventions/activities:

- Maintain at the worksite current policies and procedures including a HCPCFC PHN scope of work and duty statement that clearly articulates PHN duties and responsibilities.
- Actively participate in the care planning and coordination for the foster child and youth. Assist the case manager with arranging for comprehensive health, including mental, developmental and dental health care as needed.
- Provide outreach and education to the case manager, SCPs, foster youth, the medical community and the community at large regarding the health care needs of foster children and youth.
- Attend staff and/or unit meetings in child welfare and/or juvenile probation to promote a team approach.
- Attend and actively participate in case conferences to further promote a team approach and to ensure the coordination and access to health care.
- Assure the integrity of the health information documented in the HEP.

¹ American Academy of Pediatrics

- Actively participate in the foster care/juvenile probation PHN network to promote continuity of care and best practices.

Consultation and Care Coordination for Out-of-County Placements

The purpose of this guideline is to assure statewide uniformity for peer to peer HCPCFC PHNs consultation and health care coordination for children/youth placed outside of their county of jurisdiction, or transferred into a new county of jurisdiction.

On behalf of the child, the HCPCFC PHN works collaboratively with a variety of programs and systems to assist the case manager to assure:

- Timely communication with the foster care team members
- Relevant consultation on health care needs
- Effective collaboration with the principle parties involved in case supervision and provision of services
- Accurate and timely documentation in the case record

Goal:

Each child in out-of-county placement shall receive timely and appropriate health care services consistent with the case plan.

Guidelines:

To accomplish this goal, HCPCFC PHNs will collaborate with their HCPCFC PHN counterparts and foster care team members in the relevant counties to ensure that the health care needs are addressed and documented in the CWS/CMS, HEP, or its equivalent.

Specifically:

1. The case manager and the HCPCFC PHN in the county of jurisdiction are responsible for care coordination and documentation of health care services for the child/youth in out-of-county placement. The HCPCFC PHN in the county of jurisdiction and the HCPCFC PHN in the county of placement will consult with each other on the needed care coordination activities once they become aware of the out-of-county placement status of the child.
2. The HCPCFC PHN in the county of placement will provide a list of health care providers and community support services to the county of jurisdiction foster care team as needed. Further involvement in care coordination, i.e., facilitating referrals, follow-up on health service needs, and consultation with the SCP will depend upon the complexity of the health services needs and the availability of the HCPCFC PHN in the county of placement.

Case Scenarios:

Situation 1:

When the jurisdictional responsibility for the child/youth is transferred from one county to another county,

1. The HCPCFC PHN and the case manager in the county of jurisdiction work together to address health care needs and keep the HEP up-to-date.
2. When notified of the transfer-in, the HCPCFC PHN in the county of jurisdiction may contact the HCPCFC PHN in the previous county to confer on the health care services needs of the child/youth.

Situation 2:

When the child/youth is placed outside of the county of jurisdiction, the Juvenile Court of the county of jurisdiction maintains responsibility even though the placement is in another county. The case stays with the case manager in the original county of jurisdiction. Health care services are usually provided in the county of placement.

1. The HCPCFC PHN and the case manager in the county of jurisdiction assure the health care needs are addressed and documented in the CWS/CMS, HEP, or its equivalent.
2. The HCPCFC PHN in the county of placement will provide a list of current health care providers and community support services as needed.
3. The HCPCFC PHN in the county of placement may be requested to:
 - a. Assist in providing resources for the child and their family
 - b. Collaborate with the HCPCFC PHN in the county of jurisdiction for coordination of health care needs
 - c. Participate in case conferences as necessary

Situation 3:

When the child/youth is placed outside of the county of jurisdiction, the original county Juvenile court maintains responsibility, and then contracts with the county of placement for selected supervision and services. Case supervision and services are outlined in the written agreement (contract) between the contracting counties. Health care services are usually provided in the county of placement.

1. The HCPCFC PHN in the county of jurisdiction will work with the case manager to assure health care needs are addressed and documented in the CWS/CMS, HEP, or its equivalent.
2. The HCPCFC PHN and the case manager in the county of jurisdiction assure that all health information including the HEP is sent to the county of placement in a timely manner.

Note: Key to the success for the HCPCFC PHN consultation and care coordination is prompt notification from the case manager of the location of the child/youth, and the terms of the written agreement regarding the health care services.

Key Elements to Support Children's Transfer between Counties

HCPCFC-PHNs in the county of jurisdiction must have:

- Access to past, current, and future health care needs and services for the child/youth
- Contact information of the HCPCFC PHN and the foster care team members in the county of placement who are responsible for the case planning, supervision and services. Prompt communication through the use of the telephone, email, fax, and/or CWS/CMS
- Information on the jurisdiction and current placement from the case manager who is requesting health services consultation for the child/youth. Timely and accurate notification of placement changes is essential (via CWS/CMS or contact with the child welfare services supervisor)
- Access to the case manager in the county of jurisdiction for consultation on Medi-Cal issues, i.e. Medi-Cal eligibility determination, Medi-Cal aid code transfer, Medi-Cal Managed Care Plan dis-enrollment and secondary residence assignment, and removal of Other Health Coverage code from the Medical Eligibility Data System (MEDS)
- Active knowledge of the health provider resources and community support services for child/youth in the county of placement

- Access to local CHDP program personnel for information on the health provider network and the coordination of resources for the child/youth as needed

Juvenile Probation

The following guidelines are for the HCPCFC PHN working with Juvenile Probation Title IV-E eligible youth in out of home placement.

The HCPCFC PHN:

- Consults with Children's Medical Services, CHDP and Juvenile Probation Department regarding the HCPCFC PHN's Interagency Agreement (IAA) and MOU, for areas of PHN responsibility and coordinating activities. This may include collaboration, provision and coordination of mandated services, and sharing Protected Health Information (PHI) on behalf of Juvenile Probation youth in out of home placement.
- Establish a procedure with the Juvenile Probation Department to alert the HCPCFC PHN of the youth's placement in foster care. HCPCFC PHN may receive placement alerts from Juvenile Probation using secondary assignment in CWS-CMS, email, or other methods to communicate the child's detention and suitable placement in foster care. Implement use of the CHDP reminder letter for basic and intensive informing. The CHDP reminder letter can be sent to the SCP, who can be a foster parent, Foster Family Agency, group home, or relative placements regarding the foster youth's health care needs.
- Consult with multi-disciplinary health providers while advocating for the health care needs of Juvenile Probation youth in out of home placement, within or outside-of-county of jurisdiction. Multi-disciplinary providers might include the medical home, medical or dental specialist, behavioral health, early start specialist, managed care or eligibility staff.

- Assist SCPs in obtaining the initial comprehensive CHDP physical examination or an equivalent examination. The CHDP physical examination is the preferred health assessment for children and youth in foster care due to the integration of medical and dental, child and adolescent development, mental health screening and referral to specialist, as needed.
- Educate SCPs regarding local health provider or community services, as well as utilization of local resources to impact the health of the foster youth placed by the Juvenile Probation Department.
- Maintain a HEP for each Juvenile Probation youth and update periodically as health information is received. Examples of health information sources used to update the HEP include, but are not limited to: PM 160; JV 220 Order for Psychotropic Medications; JV 225 Your Child's Health and Education form; Health Contact Forms or an equivalent, medical records or reports.
- Orient Juvenile Probation Department staff regarding the role of the HCPCFC PHN working in Juvenile Probation Department. Provide ongoing education to SCPs on the role of the HCPCFC PHN working in Juvenile Probation Department.
- Provide Juvenile Probation Department staff and SCPs with ongoing education regarding health issues that impact the health and wellbeing of youth in out of home placement.
- Participate in meetings and case reviews that relate to the HCPCFC PHN working with the Juvenile Probation Department, such as:

Regional Deputy Director Foster Care Subcommittee

Probation Youth in Foster Care committee

Local CHDP Meeting

Juvenile Probation Department Meeting

Juvenile Probation Case Review

- Attend professional trainings and conferences on topics relating to local Juvenile Probation Department, youth in out of home placement, and the Juvenile Justice System.
- Trainings of interest to the new and experienced HCPCFC PHN might include Drug Endangered Child (DEC), AB 12 Implementation, Adolescent and Teen Health, Juvenile Probation regulations, and sharing of PHI.

Resources that Support the Role of the PHN

County/Community Resources

Identifying sources of information within and out of the county and the links for coordinating services for children in foster care are necessary foundations for the foster care PHN to function effectively. The only way to get the job done is to build and cultivate relationships.

The sources of information and the links for coordinating services become visible as you ask and accumulate answers to several questions. To most effectively obtain answers to these questions, initiate meeting with a variety of people who work with or support children in foster care. Use the meeting as an opportunity to begin building your relationships.

Several questions transcend positions or agency, such as:

- Who are the players?
- What are their programs and/or responsibilities?
- What are their needs for health care assistance?
- How do they view the foster care PHN role? Is it consistent with your view?
- How is information exchanged with the foster care PHN?
- What do they see as pressing issues?

To get started, the following are some people to meet early on, as well as, some suggestions for additional questions or areas of focus.

1. Human Services Department

a. Unit Supervisors for:

- 1) Emergency Response
- 2) Family Maintenance
- 3) Family Preservation
- 4) Court Services
- 5) Family Reunification
- 6) Permanency Planning
- 7) Any other units or programs, such as, specialized foster care home, or Independent Living Program (ILP)

b. Licensing Workers – Is there any pattern to incidents investigated that suggests a need for health care, medical or safety training? How does licensing and placement work together to match a child needing placement with a caretaker? When is the PHN consulted?

c. Eligibility workers – Are specific workers assigned for foster care? Establish a contact person.

d. Social Workers or Child Welfare Workers – To initially introduce yourself, request to attend unit meetings.

e. CWS/CMS Support Person – What is the PHN's access to the system? Who is designated in the county to receive any change requests?

f. Clerical and legal clerical staff.

2. Children's Shelter

- a. Shelter Supervisor
- b. Medical/Nursing Coordinator – How is continuity maintained and follow-up assured after child leaves the shelter?

3. Juvenile Hall – Identify and meet coordinator for medical/health services.

4. CHDP

a. PHNs working in other programs

- 1) What is CHDP?
- 2) How do children in foster care interface with the CHDP Program?
- 3) What resources are available through CHDP?
- 4) How can the CHDP provider network be accessed?
- 5) What assistance is available for referrals to specialists, other programs, community resources?
- 6) How can CHDP help with accessing services for children and for youth placed out of county?
- 7) Establish a contact person at CHDP.

b. CHDP PHNs

- 1) What are the protocols for intensive informing (PM 357/SAWS) and follow-up care (PM 160) for children in foster care within the county, when placed out of county, and for placements from other counties?
- 2) In what projects is CHDP involved jointly with other programs, agencies, community clinics, etc?
- 3) Identify the CHDP and California Children's Services (CCS) liaisons to the Managed Care plans if you have managed care in your county.
- 4) Identify the CCS liaison to the Regional Center and Early Start.
- 5) Locate the CHDP Provider Manual and Health Assessment Guidelines.
- 6) Locate and become familiar with Program Letters, Provider Letters and Information Notices.

5. County Medi-Cal Managed Care Plans

a. Medical

- 1) What type of managed care plan(s) is in your county?
- 2) How are children in foster care provided services when they live within the county, when placed out of county?
- 3) Establish a contact person (at each plan if there is more than one in the county).

b. Mental Health

- 1) How are children in foster care provided services when they live within the county, when placed out of county?
- 2) What services are available for immediate care needs?
- 3) What are the procedures for obtaining out of plan benefits, e.g., Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Services?
- 4) Establish a contact person.

6. Partial List of other resources

a. Identify a contact and set up a meeting to learn about services provided by the following:

- 1) Regional Center
- 2) Easter Seals
- 3) CCS
- 4) Special Education Local Planning Area (SELPA)
- 5) Court Appointed Special Advocates (CASA)
- 6) Field Public Health Nursing
- 7) Hospital Pediatric and Nursery Discharge Coordinators
- 8) School Nurses
- 9) WIC
- 10) Any Large Clinic/Provider

- 11) HIV Prevention Unit
- 12) High Risk Infant Program
- 13) Parenting Program
- 14) Drug Alternative Program
- 15) Attorneys for children in foster care
- 16) Groups such as Children and Adults with Attention Deficit Disorder (CHADD), Child Abuse Council, Foster Parent Association, Grandparents Parenting Again, etc.

b. Ask about:

- 1) Grants/Scholarships
 - a) Are there any program grants available?
 - b) Does the Foster Parent Association offer scholarships, and if so, for what purposes?
- 1) Special Funds, e.g., Special Care Incentives and Assistance Program (SCIAP). Note the information on SCIAP in Section 1.
- 2) Community or Volunteer Programs, e.g., Lions Club for eye glasses, or Elks Major Project for physical therapy, occupational therapy, speech therapy.
- 3) Other Children's Health Programs
 - a) Healthy Families
 - b) Kaiser Permanente Care for Kids
 - c) California Kids

Written Resources

Numerous documents are available to assist with understanding the Child Welfare System (CSW) and how it is regulated, to define policies and procedures for all involved in the CSW, and to keep up with changes. There are also written plans or agreements defining how agencies will work together. Locate the following:

1. Foster Care Regulations and information
 - a. All County Welfare Directors Letters (ACWDL)
 - b. Welfare and Institutions Code – Section 300 of the Regulations

- c. Title 22, Division 6, Chapter 7.5 – Foster Family Homes
 - d. Division 31 Child Welfare Services Program Manual of Policies and Procedures
 - e. References to special populations, e.g., Immigrant status
2. Foster Care Protocols, such as HIV Risk Assessment, Medically Fragile Infant, Teen Pregnancy, etc.
 3. Memorandum of Understandings (MOUs) or Interagency Agreements (IAAs) between CHDP and Human Services Department, CHDP and Mental Health and CHDP and Medi-Cal Managed Care.
 4. Title 17, Subchapter 13 CHDP
 5. Medi-Cal Provider Manual, Denti-Cal Provider Manual.
 6. Community Resource Guides for Domestic Violence, Mental Health Services, Advocacy Groups, such as MATRIX, Early Start, Teen Parenting, County Human Services Resources Guide, etc.

Foster Care Providers

The greatest resources for our children and youth in foster care are the foster parents, group homes, or other facilities who provide the 24 hour care and supervision for these children. A major role of the child welfare worker, foster care PHN, and all of the previously mentioned resources is to support foster parents in this endeavor.

Choice of foster placement is dependent upon a number of factors, such as the child's needs, availability of a relative to care for the child, foster home availability, skill level of care giver to meet child's needs, etc. The following are a few questions to help you start learning about your foster parents, and the foster family agencies (FFAs) or group homes in your area.

1. Individual Homes

- a. Relative care givers or Kin-Care Placements – How can you identify children who are placed with relatives? Is there a local support group for relative care givers? What financial and social service support is available for relative care givers?
- b. Non-relative care givers for foster parents - Are there specialized homes for medically fragile infants/children? Are there therapeutic foster homes, or homes which accept direct placements? What support is available to these foster parents? Is there a Foster Parent Association?

2. Group Homes

Some group homes specialize in children or youth with a particular need, such as developmental delay or substance abuse, while others may base intake on the age or sex of the children. Some are strictly for foster care placement, while others may accept private placements, or youth from the juvenile probation system. You may have a group home referred to as a “Level 12” or “Level 14”.

3. Foster Family Agencies

The County Welfare Department may contract with FFAs to provide care to children in either individual homes or in a group home setting. The FFA monitors the foster parents’ compliance with regulations and provides education and support to these foster parents. The FFAs and group homes must comply with all of the state regulations governing foster homes. Generally, children in the care of FFAs have a case worker assigned by the FFA in addition to the county child welfare worker. Establish a contact person at each of the FFAs. What type support is provided to foster parents by the FFA and what needs can the PHN address?

1. Foster Parent Needs/Resources

- a. How are these needs determined, and how are they met?
- b. Is foster care education provided through the local junior college? Meet the program coordinator.
- c. How is new foster parent orientation handled?
- d. Who coordinates the Independent Living Program? Meet the coordinator.

- e. What are the educational needs of group homes, FFAs, specialized foster parent programs, such as the Therapeutic Foster Parents?
- f. What role can the PHN play in meeting needs?
- g. Who are contacts/resources?

2. Social Workers

- a. What trainings are needed by the social workers regarding health care, medical conditions, developmental issues, health protocols, e.g., HIV Risk Assessment, and the CHDP Program? Who needs to be contacted at the Human Services Department to set up training?
- b. What consultations are needed regarding health care resources, accessing Medi-Cal, interpreting medical records, information about specific medical conditions or medications, planning/obtaining services for children being placed out of county, etc.?

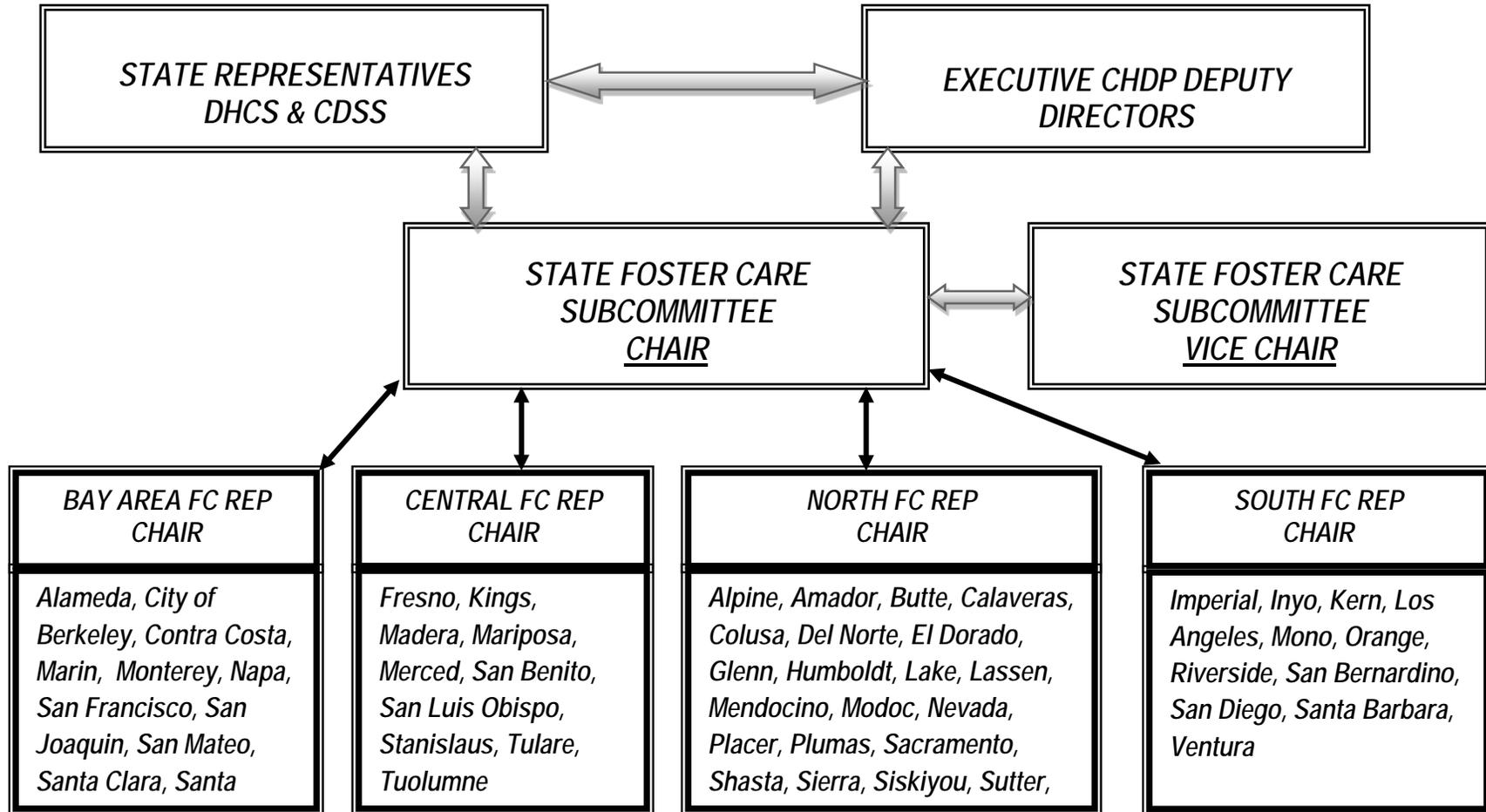
3. Eligibility Worker – Who informs the eligibility workers about the CHDP Program?

Advocating for the health care needs of children and youth in foster care will take you down many different paths. Some are straight-forward while others are most challenging with many twists, turns, and an occasional dead-end. When you wonder where to turn next...remember, a foster care PHN colleague is just a phone call away!

The HCPCFC PHN Standards of Practice was developed to answer many of the above questions and to help you navigate through the CWS and Probation confusion. If you can't find it here, you are not alone and you can always contact a PHN who is located in a neighboring county or contact the State Foster Care Subcommittee (See communication chart below).

CHDP EXECUTIVE & STATE FOSTER CARE SUBCOMMITTEE COMMUNICATION FLOW

Revised October 21, 2015



Section 4-----Health Related Performance Measures

California Children's and Family Services Review (C-CFSR)

Data is also available through the California Child Welfare Indicators Project (CCWIP) website which is a collaborative venture between the University of California at Berkeley (UCB) and the California Department of Social Services (CDSS). The project is housed in the School of Social Welfare and contains customizable data on California's Child Welfare Outcomes including quarterly reports, graphs of the measures, and a means to compare performance over time. The data is used to report on the California Children's and Family Services Review (C-CFSR) and is updated quarterly. Data can be accessed at this website: http://cssr.berkeley.edu/ucb_childwelfare/TopicDefault.aspx

Timely Medical and Dental Exams - State Measure – 5B (1) and 5B (2)

Both of these measures are part of the on the C-CFSR. Children in out of home placement must have a medical and dental exam within 30 days of initial placement and then according to the CHDP periodicity schedule ([Division 31.206.36](#)) (note: dental exams are required for children beginning at age 3 years and above -- see Oral Health section regarding CHDP recommendations to make referrals for dental exams starting at one year of age). The medical and dental exams must have a contact created in the service management notebook for the information to be identified correctly as a well exam and the data captured in CWS/CMS (see detailed instructions below). Each measure provides the percent/number of children meeting the medical (State Measure 5B (1)) and dental (State Measure 5B (2)) exams. Both measures are used to measure the Child Well-being Outcome. The methodology can be reviewed for a further explanation about these measures.

Data is also captured in CWS/CMS about the provision of the HEP to caregivers at initial and every change of placement. However the CWS/CMS needs to be queried to produce a report.

Measures 5a.1 Use of Psychotropic Medication among Youth in Foster Care and 5a.2 Use of Antipsychotic Medication among Youth in Foster Care

Measures 5a.1 and 5a.2 capture data on the use of Psychotropic and Antipsychotic Medication (respectively) among youth in foster care. The measure displays the number of children with a Medi-Cal paid claim for psychotropic medication, the number of children in foster care in the period, and the derived percentage of children in foster care with paid claim for medication during a 12-month period. The source of the data is the CWS/CMS and Medi-Cal fee-for-service and managed care pharmacy paid claims.

Measure 5F Authorization to administer psychotropic medications

This report provides the percentage of children in placement episodes with a court order or parental consent that authorizes the child to receive psychotropic medication.

Two systems are primarily used to extract and measure outcome data and produce reports:

- Safe Measures is a data analysis tool CWS uses to measure outcomes and provide statistics and reports based on information entered into CWS/CMS. Data is available from the individual SW to statewide levels: data is extracted, analyzed and posted twice weekly from CWS/CMS.
- Business Objects Reports is another method for obtaining, analyzing and reporting data from CWS/CMS; see your county administrator for more information about Business Objects Reports.

Children's Medical Services Plan and Fiscal Guidelines

The DHCS Systems of Care require that the local HPCFC program use the Children's Medical Services Plan and Fiscal Guidelines to report on care coordination of their children. This information must be submitted as part of the county's annual budget plan. Information on this requirement and respective forms can be found at:

<http://www.dhcs.ca.gov/formsandpubs/publications/Pages/CMSFG1314.aspx>

Section 5-----Child Welfare Services/Case Management System

Introduction

CWS/CMS is a statewide computer system that was implemented to automate the case management, services planning, and information gathering functions of child welfare services as well as to extract data and measure outcomes for families involved in the dependency and/or delinquency system. There are several case management functions in the database including the ability to document and store health and education information for children in out of home placement. The HEP, which is provided to the SCPs and medical providers, is generated from health and education information entered in to CWS/CMS.

CWS/CMS has 6 main case management pathways: Referral, Client, Service, Placement, Court and Case Management which connect you to specific Notebooks. The majority of health information is placed in the Client Management/Health Notebook (see CWS/CMS Quick Guides for New Users Illustration below).

Each HCPCFC PHN accessing CWS/CMS should receive training, through the local CWS department, about how to use CWS/CMS: below are lists of online resources for training materials related to the child welfare system in California and CWS/CMS.

Child Welfare Services/Case Management System Training Resources

Online Trainings

- [California Social Work Education Center](#)
- [Fresno State Quick Guide Booklets](#)
- [CWS/CMS Online Training Center](#) (requires login)
- [Documenting Psychotropic Prescriptions Quick Guide February, 2009](#)

Welfare Training Academies

Welfare training academies provide regional trainings for staff working within CWS on a variety of topics, including how to use CWS/CMS.

- The [Regional Training Academy \(RTA\) Project's](#) coordinating partners provide a continuum of training and professional education to county staff across the state.
 - [Academy for Professional Excellence](#) (including the Public Child Welfare Training Academy, Southern Region (PCWTA)) at San Diego State University
 - [Bay Area Academy](#), at CSU, Fresno Department of Social Work
 - [Central California Training Academy](#), at CSU, Fresno Department of Social Work
 - [Northern California Training Academy](#), at the Center for Human Services, UC Davis Extension
 - [Inter-University Consortium/Los Angeles County Department of Children and Family Services Training Division](#)

CWS/CMS Data Resources

- [Safe Measures](#) (CWS sets up individual accounts for access)
- [University of California-Berkeley Child Welfare Indicators Project](#)
- [** Locally, the HCPCFC PHN can meet with the CWS/CMS analyst \(or Help desk\) to assist with data inquiries](#)
- [National Children's Advocacy Center](#) – offers a variety of trainings and symposiums from local to international levels: to better understand family court and collateral agencies

Health and Education Passport

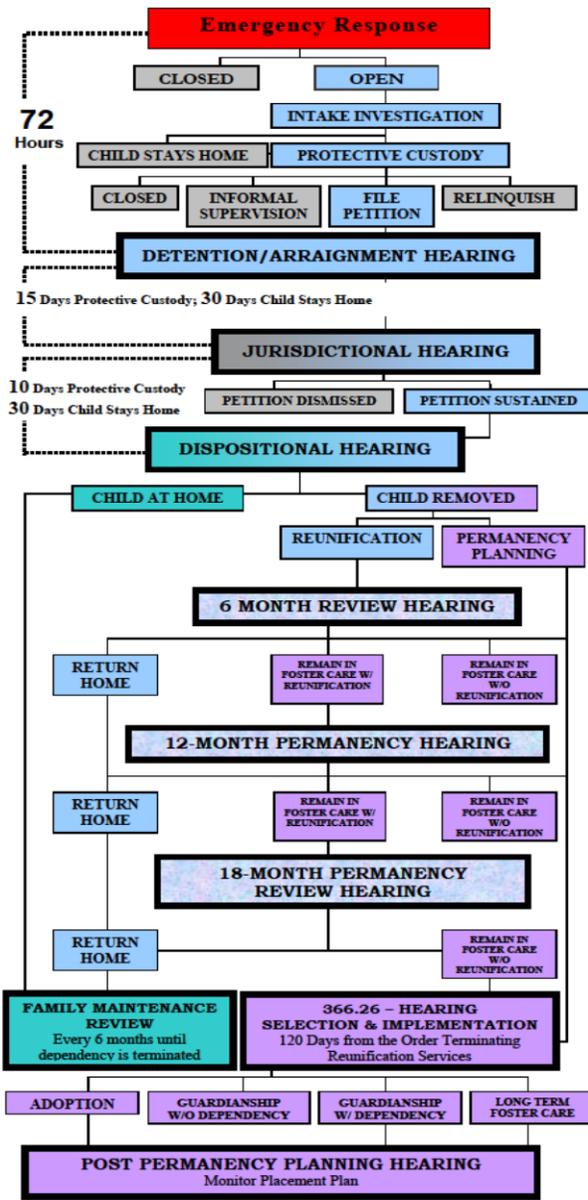
The Role of the HCPCFC PHN in Maintaining the HEP

The purpose of the HEP is to provide a tool for continuity of health care and education for children placed in foster care through the CWS dependency process and/or county Probation Departments delinquency process (flow charts for both processes are below). The HEP is a valuable document, required by law ([Welfare and Institutions Code \(W&IC\) 16010](#)) and provided to SWs/POs (SWs/POs), SCPs, health care providers, school specialists, parents and former foster youth for the purpose of communicating

pertinent medical and education information. It is started when a child enters foster care, is reviewed and updated at least every 6 months (to coincide with scheduled court hearings) while the individual remains in foster care, then sent to the parent, caregiver or youth when the youth exits foster care.

CWS Dependency Flow Chart

JUVENILE DEPENDENCY PROCESS



300 Flowchart

JUVENILE COURT DEPENDENCY HEARINGS

DETENTION HEARING: WIC 6319, CRC 5.666-5.680
Presumption: The minor shall be released to the parents unless legal grounds are established to temporarily detain the minor
Burden of Proof: Prima Facie evidence (evidence which suffices until contradicted).
Burden of Production: The government.
Time Lines: A minor may be detained in protective custody for 15 days pending a jurisdictional hearing.

DISPOSITIONAL HEARING: WIC 63100, 350, 353 / CRC 5.682-5.684
Presumption: Unexplained non-accidental serious injuries while in the care/custody of parent are presumed to be the result of abuse or neglect.
Burden of Proof: Preponderance of evidence that petition is true.
Burden of Production: The government.
Time Lines: 15 days after the Detention hearing if child is out of home, 30 days if child remains home.

DISPOSITIONAL HEARING: WIC 63600-362.6 CRC 5.690-5.703
Presumption: None.
Placement: The minor shall be placed in the custody of the parents unless clear and convincing evidence of detriment. If the Court removes a minor from a custodial parent:
 > The minor will be placed with a previously non-custodial parent unless such placement would be detrimental.
 > Preferential consideration for placement will be given to a request by certain relatives.
Reunification: Parents will usually receive reunification services.
Burden of Proof: Clear and convincing evidence of substantial risk of danger to child in order to remove from parent's custody.
Burden of Production: The government.
Time Lines: 10 days after the Jurisdictional hearing if child is out of home, 30 days if child remains home or if government seeks to deny reunification services.

SIX-MONTH REVIEW HEARING: WIC 63664, 366.21, 366.22 CRC 5.710
Presumption:
 > The minor shall be returned to the parents unless there is a substantial risk to the minor's physical or emotional well being or when the parents have failed to participate regularly in any Court ordered treatment programs.
 > If minor remained home, terminate dependency unless continued supervision is necessary.
Burden of Proof: Preponderance of evidence. (If government wants to terminate Reunification Services, must be clear and convincing evidence).
Burden of Production: The government.
Time Lines: 6 months from the "entry into foster care". "Entry into foster care" is defined as date of Jurisdictional Hearing or 60 days after initial removal, whichever comes first.

TWELVE-MONTH PERMANENCY HEARING: WIC 63664, 366.21/609, CRC 5.714
Presumptions:
 > The minor shall be returned to the parents unless there is a substantial risk to the minor's physical or emotional well being or when the parents have failed to participate regularly in any Court ordered treatment programs.
 > If minor remained home, terminate dependency unless continued supervision is necessary.
 > When the minor is not returned to the parents, services will be terminated unless there is a substantial probability that the minor will be returned to the custody of the parents within six months or unless reasonable services have not been provided.
Burden of Proof: Preponderance of evidence, to determine if detrimental for child to return home. Clear and convincing evidence to determine if reasonable services were provided.
Burden of Production: The government.
Time Lines: 12 months from the "entry into foster care". "Entry into foster care" is defined as date of Jurisdictional Hearing or 60 days after initial removal, whichever comes first.

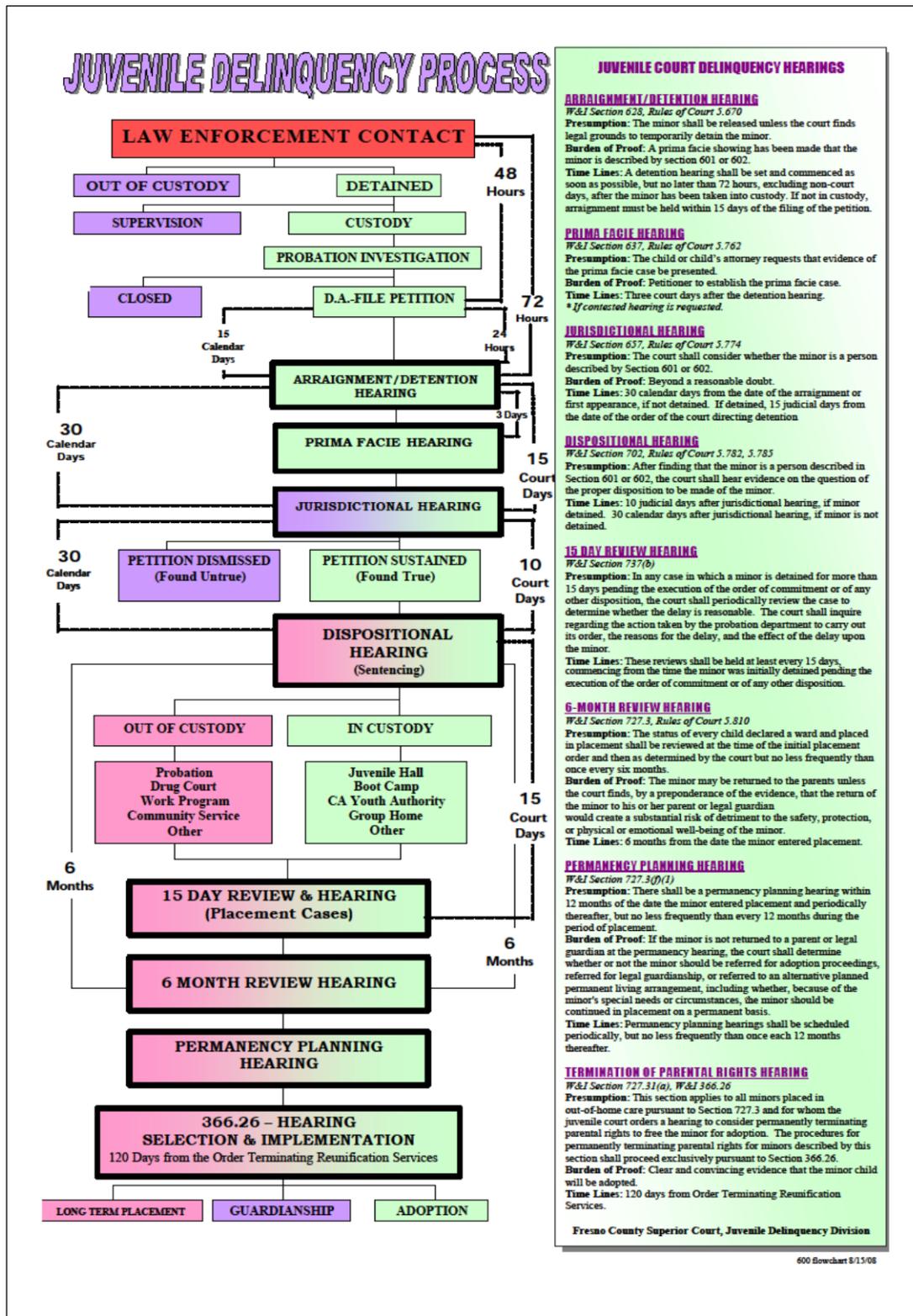
EIGHTEEN-MONTH PERMANENCY REVIEW HEARING: WIC 6366.22, CRC 5.720
Presumption:
 > The minor shall be returned to the parents unless there is a substantial risk to the minor's physical or emotional well being or when the parents have failed to participate regularly in any Court ordered treatment programs.
 > If minor remained home, terminate dependency unless continued supervision is necessary.
Burden of Proof: Preponderance of evidence.
Burden of Production: The government.
Time Lines: In no event later than 18 months after the Detention Hearing.

SELECTION AND IMPLEMENTATION HEARING: WIC 6366.26, CRC 5.724-5.741
Presumption: If the minor is adoptable, parental rights will be terminated unless adoption would be detrimental to the child.
Burden of Proof: Clear and convincing evidence that the minor child will be adopted.
Burden of Production: The government.
Time Lines: 120 days from Order Terminating Reunification Services

POST PERMANENCY PLANNING HEARING: WIC 6366.3, CRC 5.740
 This hearing determines if progress is being made to find a permanent home for the child and if the case can be dismissed.
Presumption: Continued out of home care is in the best interest of the child.
Burden of Proof: Usually preponderance of evidence.
Burden of Production: On anyone proposing a change.
Time Lines: Every six months until case is dismissed.

Fresno County Superior Court, Juvenile Dependency Division
 Revised August 2008

Probation Department Delinquency Flow Chart



Generating the Health and Education Passport

The HEP is generated from information gathered from clinic and hospital records, health encounter forms, parents, SCP, schools etc., and entered into the statewide CWS/CMS database. As information is made available, it is reviewed and analyzed by the HCPCFC PHNs to ascertain the youth's health status and identify potentially unmet health needs. The information is then included in CWS/CMS as appropriate, which will then be incorporated into the HEP. Counties have different policies and procedures regarding which staff can access/input data into the CWS/CMS system – see your county's policy regarding accessing and inputting data into CWS/CMS.

W&IC §16010 specifies and requires that CWS and Probation Departments provide HEPs to SCPs within 30 days of an initial placement, within 48 hours of a placement change, and with court reports.

W&IC §16010(a) establishes critical information to be included in the HEP including, but not be limited to:

- Well child physical and dental exams
- Health care providers' full name, title, and contact information
- Immunizations
- Allergies
- Health history to include prior hospitalizations
- Known health problems, their treatments and medications
- Developmental and mental health screenings
- Other health information deemed relevant by the HCPCFC PHN
- Education information and updates

Note: Do not document “STDs or HIV” or “Life Threatening Conditions” in the Summary of Current Health Condition. Just mark the Sensitive Health Medical information is on file for this person which refers reader to the hard copy.

Obtaining information for the HEP

W&IC 16010 includes various parties' responsibilities related to obtaining and sharing information:

“If any other provision of law imposes more stringent information requirement, then that section shall prevail.”

JV225 Health and education Questionnaire (click on JV225 below)

- At the initial hearing, the court shall direct each parent to complete “Your Child’s Health and Education” (JV-225) and/or equivalent local form and provide to the child protective agency complete medical, dental, mental health, and education information, and medical background of the dependent and the dependent’s biological mother and father if known.
- The SCP is responsible for obtaining, maintaining and communicating accurate and thorough information from health care providers to the SWs, POs and PHNs for the dependents’ HEP.
- Information received by the PHN is made available to the case manager for inclusion with court reports.

Process Illustrating the PHN Care Coordination Activities

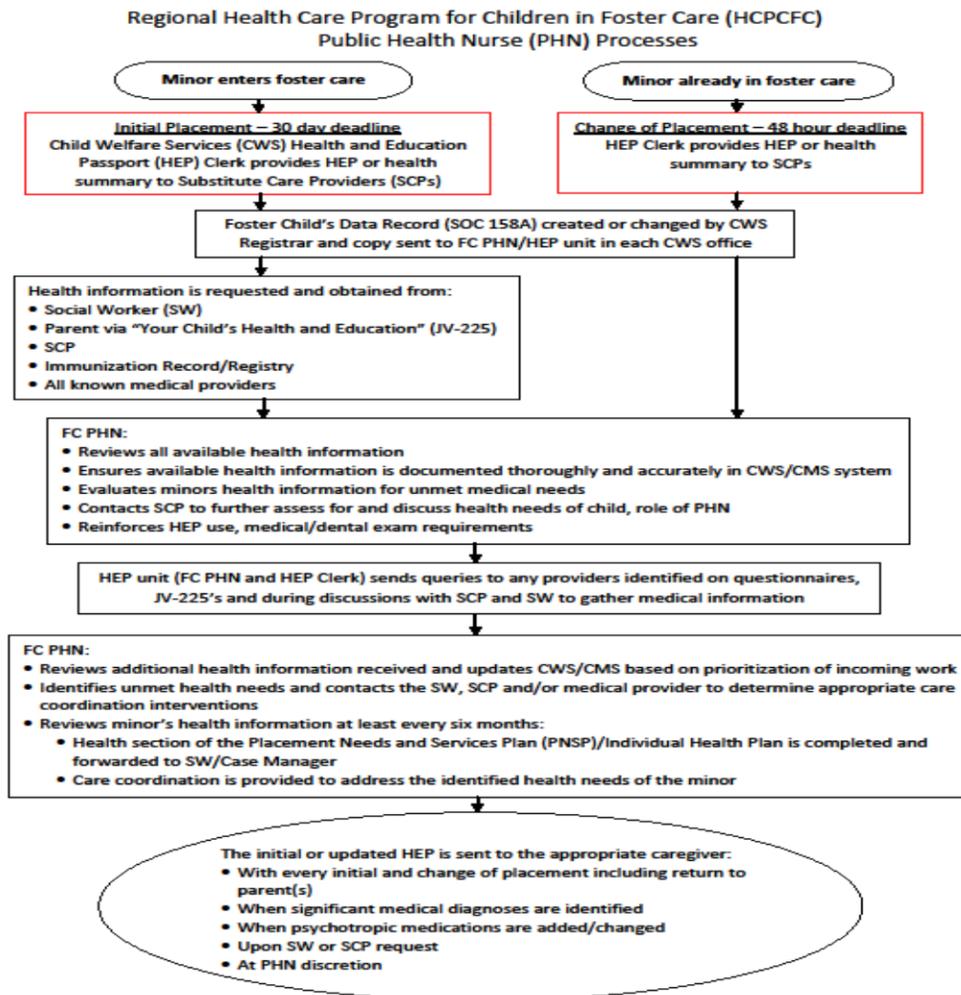
Please see flow chart below for a summary of PHN care coordination activities on behalf of children in foster care, based on W&IC §16501.3.

W&IC §16501.3 establishes the use of PHNs in CWS and Probation Departments to identify, respond to, and enhance the physical, mental, dental, and developmental well-being of children in the child welfare system.

Per W&IC §16501.3 (c) the duties of a foster care public health nurse shall include, but need not be limited to, the following:

1. Documenting that each child in foster care receives initial and follow-up health screenings that meet reasonable standards of medical practice.
2. Collecting health information and other relevant data on each foster child as available, receiving all collected information to determine appropriate referral and services, and expediting referrals to providers in the community for early intervention services, specialty services, dental care, MHSs, and other health-related services necessary for the child.
3. Participating in medical care planning and coordinating for the child. This may include, but is not limited to, assisting case workers in arranging for comprehensive health and mental health assessments, interpreting the results of health assessments or evaluations for the purpose of case planning and coordination, facilitating the acquisition of any necessary court authorizations for procedures or medications, advocating for the health care needs of the child and ensuring the creation of linkage among various providers of care.
4. Providing follow-up contact to assess the child's progress in meeting treatment goals.
5. At the request of and under the direction of the non-minor dependent, as described in subdivision (v) of Section 11400, assist the non-minor dependent in accessing health and mental health care, coordinating the delivery of health and mental health care services, advocating for the health and mental health care that meets the needs of the non-minor dependent, and to assist the non-minor dependent to assume responsibility for his or her ongoing health care management.

The HCPCFC PHN shall communicate with all parties (parents, CSWs, POs, SCPs, health care providers and schools etc.) involved in a child's care as necessary to obtain, share and update current health information for the HEP. The HCPCFC PHN will evaluate the need for and facilitate the coordination of care to meet the child's health needs mandated by related laws.



Support, Maintenance and Provision of the HEP for Non Minor Dependents in CWS and Probation Departments

Per [W&IC §16501.\(c\) 3](#), at the request of and under the direction of the NMD, as described in subdivision (v) of Section 11400, assist the NMD accessing health and mental health care, coordinating the delivery of health and mental health care services, advocating for the health and mental health care that meets the needs of the NMD, and to assist the NMD to assume responsibility for his or her ongoing health care management.

Under federal law, a caregiver is required to be provided with medical and education information regarding the child placed with the caregiver. For youth with NMD status, California meets this requirement through the HEP, see [All County Information Notice](#)

[\(ACIN\) No. 1-29-13](#). (Youth on probation may also qualify for NMD status; see [All County Letter \(ACL\) No. 11-85](#) for more information.)

- Agencies/case managers are required to provide the HEP to a caregiver when a NMD is first placed in the home, as all federal requirements that apply to a minor dependent applies to a NMD. The case manager must explain to the NMD the requirement and the benefits and liabilities of sharing this information with a caregiver. However, the HEP can only be included in a NMD's court report with the NMD's written consent [\[W&IC §16010\(b\) & \(c\)\]](#). The Foster Care PHN should consult their own county's MOU to learn what their role is in meeting this [W&IC §16010](#) mandate [\[ACIN No. 1-29-13\]](#).
- Any other stricter federal law regarding medical confidentiality for the NMD must be observed as well [\[ACIN No. 1-29-13\]](#).
- There have been several questions regarding a NMD and the CHDP annual exam. The CHDP exam is a service offered to a foster child and as such, is required to be offered to a NMD. The examination is a state requirement; however, as an adult, a NMD has the right to refuse an annual exam. The case manager and caregiver, when appropriate, should explain to the NMD why the exam is important to help maintain good health. [\(ACIN No. 1-29-13\)](#)

Additional PHN Responsibilities

Based on California laws, there are IAA and MOU templates available from the state which help counties define responsibilities of HCPCFC PHNs, CWS Agencies, Probation Departments and CHDP in meeting the medical needs of children in foster care. The templates for these documents are available on the [Children's Medical Services \(CMS\) Branch Plan and Fiscal Guidelines website](#).

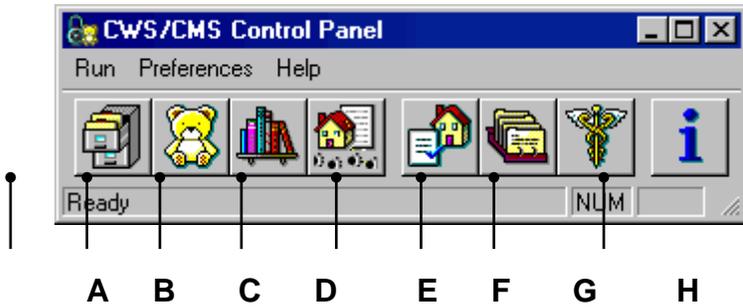
These responsibilities include:

- Communicating between the case manager and HCPCFC PHN to ensure HCPCFC PHN is aware when youth enters through the dependency or delinquency system
- Informing SCPs of CHDP services and assistance with accessing these services
- Educating SCPs of resources available in the community
- Educating CWS/Probation Department staff of role of HCPCFC PHN
- Educating SCPs, CWS and Probation staff of health issues impacting children in foster care
- Attending CWS/Probation Department multidisciplinary case reviews and consultations to assist with identification of health issues impacting CWS/Probation Department family cases
- Attending meetings and trainings related to HCPCFC PHNs working in CWS and Probation Departments
 - Meetings
 - As a regional representative, attend the HCPCFC Executive Subcommittee
 - Regional Deputy Director Foster Care Subcommittee
 - Regional CWS Training Academies
 - Probation Youth in Foster Care committee
 - Local CHDP Meeting
 - Juvenile Probation Department Meeting
 - Juvenile Probation Case Review
 - Trainings, such as, but not limited to:
 - Drug Endangered Child (DEC)
 - AB 12 Implementation
 - Adolescent and Teen Health
 - Juvenile Probation regulations
 - Sharing of PHI (protected health information)

CWS/CMS Quick Guides for New Users

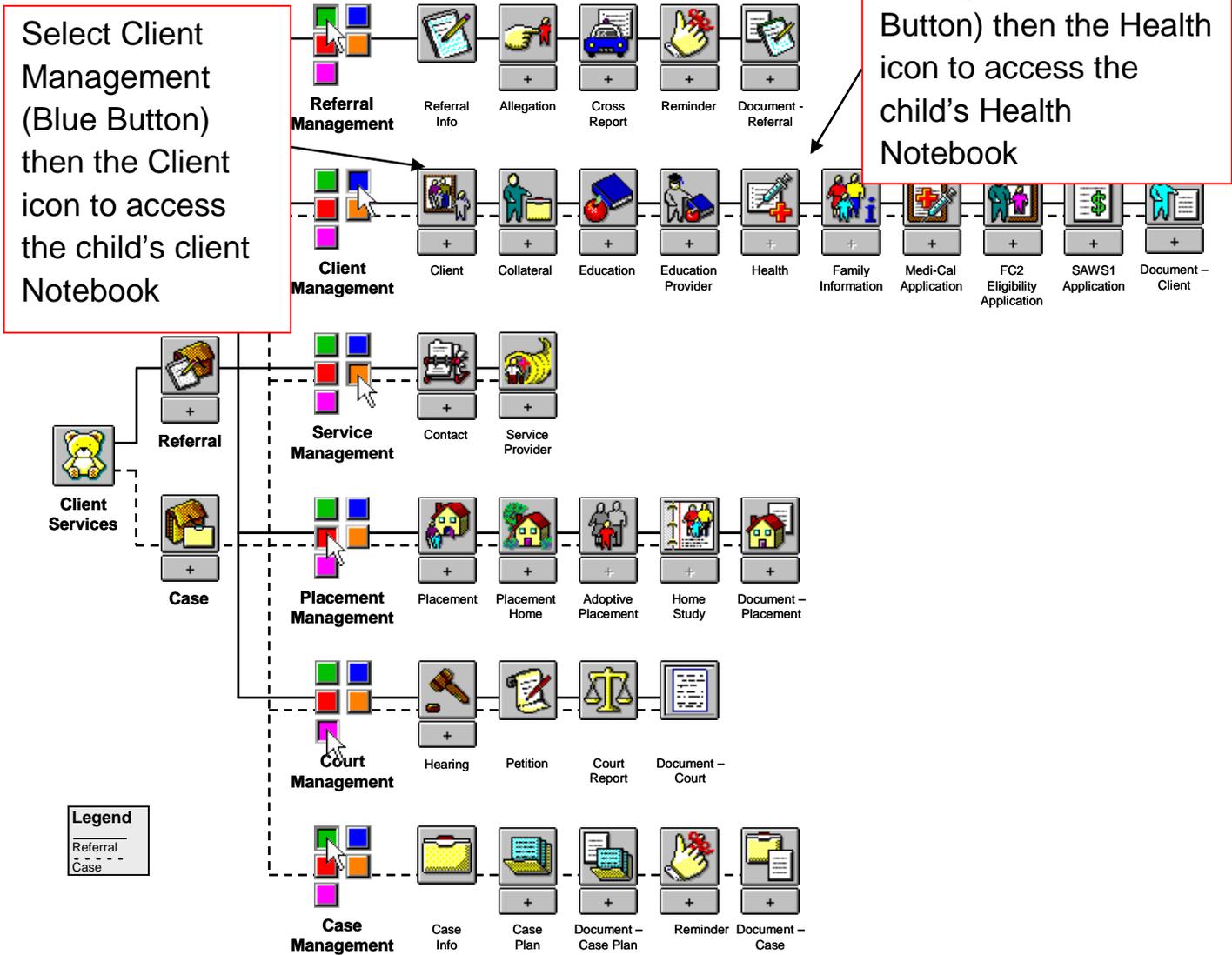
(Information below is adapted from guides created by Terry Luna, CWS/CMS Project Coordinator, terril@csufresno.edu)

CWS/CMS Control Panel

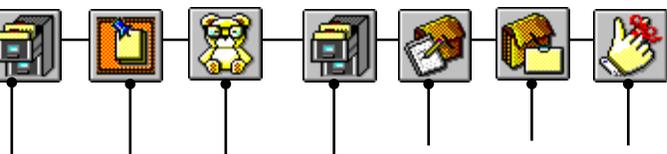


- A. Caseload
- B. Client Services
- C. Resource Mgmt.
- D. SOC 158
- E. LIS
- F. CDS
- G. MEDS
- H. System Information

Client Services Notebook Map

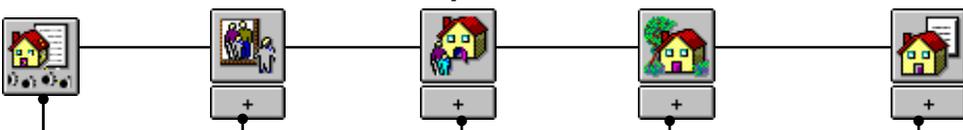


Caseload Notebook Map



Case Bulletin Supervisor Caseload Referral Case Reminder

Placement Notebook Map



SOC 158 Client Placement Placement-Home Document-Placement

NOTEBOOK DESCRIPTIONS

Client Notebook – several pages of this notebook populate the passport with basic child information. The ‘service provider’ page will populate past and present health service providers of the child.

Education Notebook – this notebook populates the passport with past and present educational information for the child.

Health Notebook – this notebook populates the passport with all relevant health history for a child, including ‘diagnosed conditions’, ‘medications’, ‘hospitalizations’, ‘immunizations’, etc.

Contact Notebook – The Associated Services page of the contact notebook must be used to document CHDP – Physical & Dental Exams. Only Well Physical and Dental exams with an HEP indicator will populate to the passport.

Placement Notebook – Use the ID page of this notebook to document the ‘date SCP informed of the CHDP program and that brochure was given’; if ‘SCP requests CHDP services’; and ‘date SCP was given the HEP and informed of its purpose’.

Using CWS/CMS: General Hints that Work in all Cases and Referrals

Date Fields

- Use Calendar to select date
- Highlight field, type in date
- Double click to enter today’s date

Time Fields

- Highlight field, type in time
- Type over a.m. / p.m.
- Double click for current time
- Not military time – but must be 4 digits

Text Fields

- Will accept numbers / letters
- Limited amount of text

Radio Buttons

- Choose only one

Information Grids

- Purpose is to collect history
- To add history, use plus sign to add a numbered row
- Never change an existing row – you will lose history

Context Specific Help

- Put cursor in the field, press F1
- Will work on any field in CWS/CMS

Edit – View Audit

- Put cursor in the field, press View Audit. This can tell you who created the field, and who last updated the field
-

Highlighted Fields

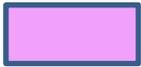


Yellow Fields must be complete before CWS/CMS will save information to the database

Completion of some non-mandatory fields may cause other fields to become mandatory



Green Fields must be completed to meet federal requirements



Periwinkle Fields identify outcome measures and should be completed when information is available. There is an example of a periwinkle field under the Birth History tab of the Health Notebook; there is also a field in the Client Notebook for entering birth information from birth certificates, this information should populate to the Health Notebook, any editing will then be reflected in both Notebooks.

Save to Database

- Save to database after completing each case

Accessing CWS/CMS

Opening CPS Cases & Referrals

SEARCH – Start Search

Enter Search criteria here:

Field	Value	Checked
Last Name	L	<input checked="" type="checkbox"/>
First Name	Pedro	<input checked="" type="checkbox"/>
Middle Name		<input type="checkbox"/>
Social Security Number		<input type="checkbox"/>
Gender	Male	<input checked="" type="checkbox"/>
Approximate Age	11	<input checked="" type="checkbox"/>
Ethnicity		<input type="checkbox"/>
Street Number		<input type="checkbox"/>
Street Name		<input type="checkbox"/>
City		<input type="checkbox"/>
County of Residence	Sacramento	<input type="checkbox"/>
State	California	<input type="checkbox"/>
ZIP Code		<input type="checkbox"/>
Date of Birth		<input type="checkbox"/>
Home Phone		<input type="checkbox"/>

Phonetic Name Search
 Phonetic Street Name Search
 Partial Address Match

Hints for Opening Cases & Referrals using:

Name

Remove check mark from *Phonetic Name Search* to eliminate similar name matches in search results.

Date of Birth

Include county number, in addition to birthdate, in appropriate row to eliminate out of county matches.

19 digit Client ID Number

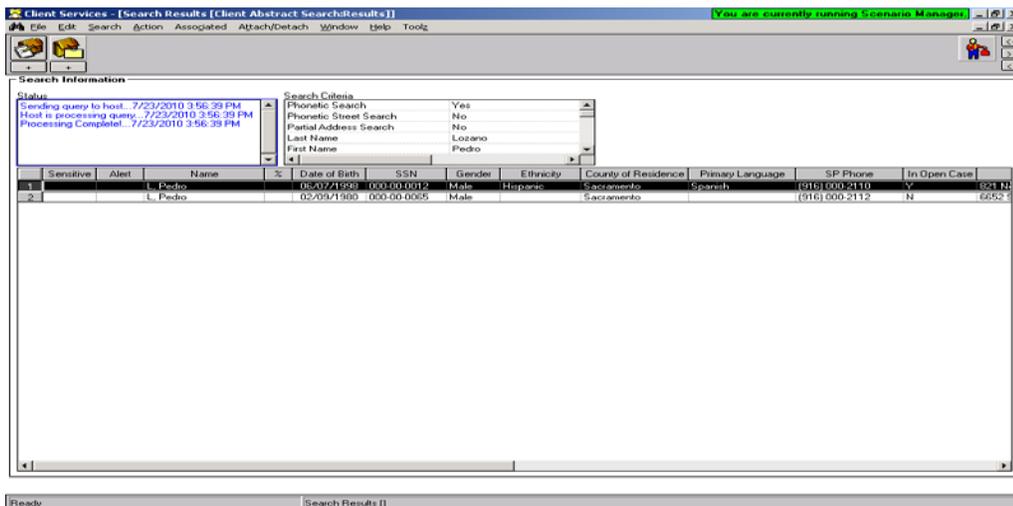
Under the File menu, select FIND FOLDER – choose Case or Referral, then enter the 19 digit serial number.

Open Associated Referrals/Cases from existing Case/Referral

When you are in a case or referral you can access all previous referrals and cases from Client Management section (blue) – open any client notebook. Then choose Open Associated Cases or Referrals from the menu bar.

Search Results will display possible matches.

Choose the best one and double click to bring up the Abstract.



The 'Client Abstract' is a snapshot of the client – you can use the abstract to determine if this is the client you are looking for.

The screenshot shows the 'Identification' tab in the Client Services software. The client's name is L. Pedro. The form contains the following information:

- Last Known Residence Address:** 821 No Way, Sacramento, CA 95819
- SSN:** 000-00-0012
- Gender:** M
- Primary Ethnicity:** Hispanic
- Date of Birth:** 06/07/1938
- Age:** 12
- Outstanding Warrant:**
- Client ID:** 106545143204-0000018
- Birth Place/Hospital Name:** Indio
- Birth City:** [Empty]
- Alien Registration #:** [Empty]
- Emigration Country:** [Empty]
- Drivers License #:** [Empty]
- Last State ID #:** [Empty]

There is also a section for 'Parental Rights Termination' with a table that is currently empty.

Use the 'Referral History' tab to determine if client has history with Child Welfare Services.

Use the 'Case History' tab to determine if the client has or has ever had a case open in Child Welfare Services.

The screenshot shows the 'Case History' tab in the Client Services software. It displays a table of cases related to the client:

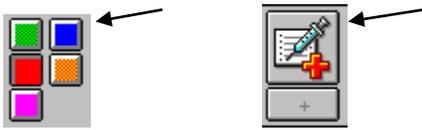
Case ID	Case Name	Start Date	End Date	County
1 1610-9563-8621-6000018	L. Pedro	08/03/2004		Sacramento
2 1361-4514-7735-2000019	L. Pauline	09/03/2004		Sacramento

Below the table, there are fields for 'Last Service Component' (Family Reunification) and 'Last Office Name' (Downtown Sacramento). There is also a 'Case Closure Reason' field and a 'Name' section with fields for Name (W. Chris), Phone ([916] 000-2110), and Ext.

Select the Associated menu at the top of the screen, then 'Open Associated Referrals or Cases' to open any existing referrals or cases. You can only open your own counties cases or referrals. Sealed or sensitive cases/referrals can only be opened by individuals with that privilege.

Accessing the Health Notebook

Open the Health Notebook



CREATING THE HEP

The HEP is created from information entered into several Notebooks throughout CWS/CMS. Information cannot be entered directly onto the Passport.

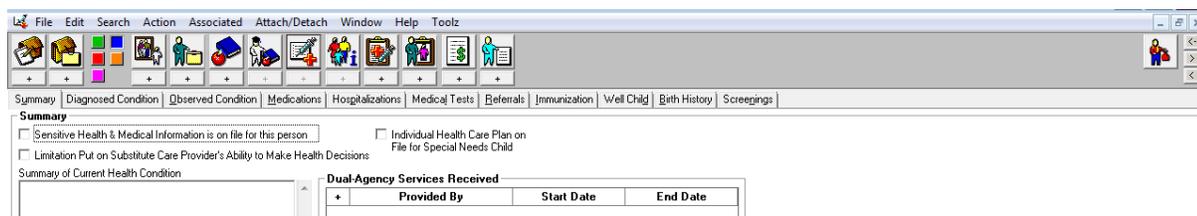


Content, Review and Update of the HEP

The following tabs will allow you to enter health information which will populate to the Health and Education Passport when it is created.

Keep wording concise; the Health Notebook is not designed for narrative progress notes.

Health Notebook specific procedures and data management may vary from county to county; use your county's specific procedures when placing info in Health Notebook.



Summary This tab can be used to summarize:

- Child's current diagnoses
- List exam due dates
- Immunizations to be determined by medical provider
- Positive toxicology results (date, chemical, value)
- Developmental Delays

Diagnosed Condition Use this tab to record any conditions a child has which are diagnosed by a practitioner or a clinic. Record as much information about the condition as possible. Use start and end dates to document child's health history. **If an entry includes a check in the alert box, the condition will populate to beginning of the health information page of HEP.**

Observed Condition Use this tab to record any conditions a child may have that have been observed by someone. Record as much information about the condition as possible. Use start and end dates to document child's health history. **Observed Conditions will only print to passport if the alert is checked.**

Medications Use this tab to document any medications prescribed for a child. Each medication must be tied to a 'Client Condition' **(which comes from the 'Diagnosed Conditions' page.)**

Hospitalizations Use this tab to document anytime a child has been hospitalized. The hospitalization must be tied to a 'Client Condition'.

Medical Tests Use this tab to document any medical tests ordered for a child and those test results. The medical tests must be associated with a 'Client Condition'.

Referrals Use this tab to document any medical referrals made on behalf of a child by a Health Provider. The referrals must be associated with a 'Client Condition'.

Immunization Use this tab to document a child's immunization history.

Well Child This tab is where you will see recorded well medical and dental exams. You must create a Contact including an Associated Service in the Service Management Section to correctly record Well Physical and Dental Exams that meet the exam requirements and populate to the Well Child tab.

Birth History Use this tab to enter birth history information for a child. This is a good place to record a toxicology screening. Certain information on this page is duplicated on the Demographic page of the client notebook. The information will cross populate to each notebook.

Screenings Use this tab to document developmental and mental health screenings, referrals and referral status

Service Providers Use this page to show service providers involved with client (instructions are below). Use the plus + sign to add service provider then include the start date. Service providers with no END date will populate to the Current Service Provider section of the HEP. Providers with an END date entered populate to the 'Past Provider' section. Only Providers that have been used in a Contact will appear under the plus. Use the Search option to locate Providers that are not in the list.

Click on **Blue** button; then click on the **Service Providers** tab.



Printing the New Health and Education Passport

Use the 'Create New Document-Client' Notebook to generate HEP.



Select the Time Frame parameters from the next dialog box.

Select All from each category to populate all available information into the new HEP

This will create the HEP in Microsoft Word. It can be Saved and Printed, but **CANNOT** be edited! Any changes must be made in the Notebooks, the current HEP must be removed – and a new HEP created. There can only be ONE passport per child. The passport can be continually refreshed, by removing it and recreating it.

Creating Contacts (Entering Medical and Dental Exams)

CREATING CONTACTS (must be done to capture Well –Physical and Dental Exam data)

<p>Create New Contact:</p> <p>RECORD A CASE MANAGEMENT SERVICE WITHIN THIS CONTACT</p> 	<p>Use the Contact Notebook to record every contact (narrative) that is made on behalf of a child.</p> <p>Click on the Orange button</p> <p>Click on the + under the Rolodex icon to create a new contact</p> <p>Complete all fields with the respective information</p> <p>Or</p>
---	--

Click on Rolodex to open a previously created contact

Edit respective information

Be sure to complete all **YELLOW** fields.

RECORD SERVICES BEING PROVIDED ON BEHALF OF A CHILD

Click on the Associated Services tab.

Use the plus button in the upper left corner to add each Service provided to child. *A Well Physical or Dental Exam can be recorded for ONLY one child at a time.*

Be sure to complete all **YELLOW** fields with respective information.

Service Category = Health/CHDP Services

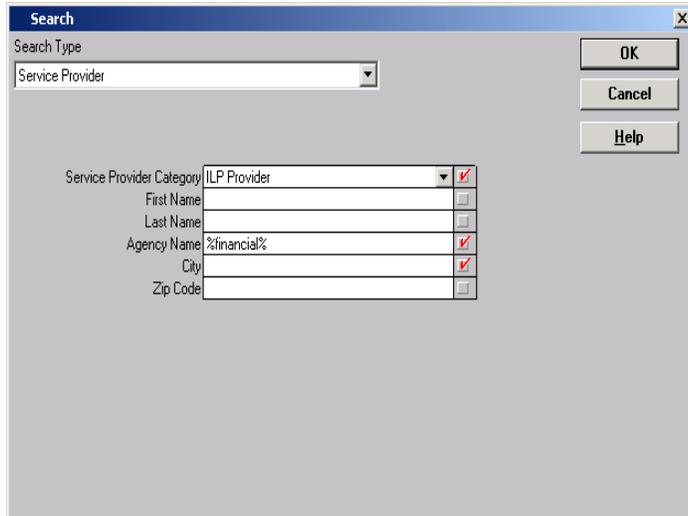
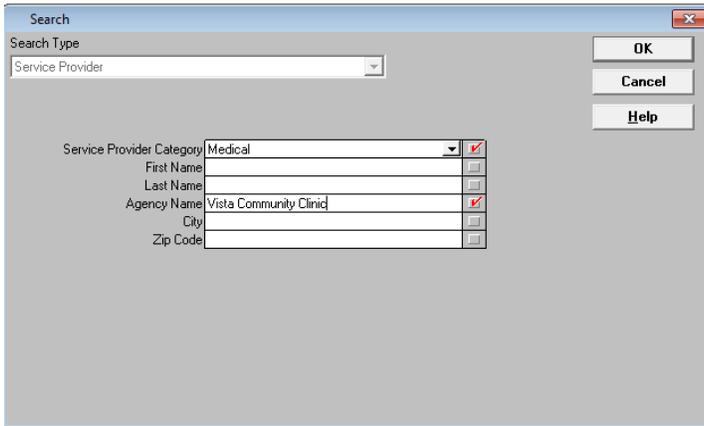
Service Type =

- HEP - CHDP Equivalent Physical Exam, or
- HEP - CHDP Physical Exam, or
- HEP - Periodic Dental Exam

Locating Providers:

Click on the arrow in the Provider Name field, select Medical Service Provider for specific visit.

If the Service Provider is not included in the dropdown list, use the Search/Binoculars/Locomotive to search the database.



Most service providers are already in the database, the trick is finding them.

SERVICE PROVIDER SEARCH Tips:

Select Medical for Service Provider Category

You can:

Search using the agency name (preferred) or provider's first and last name.

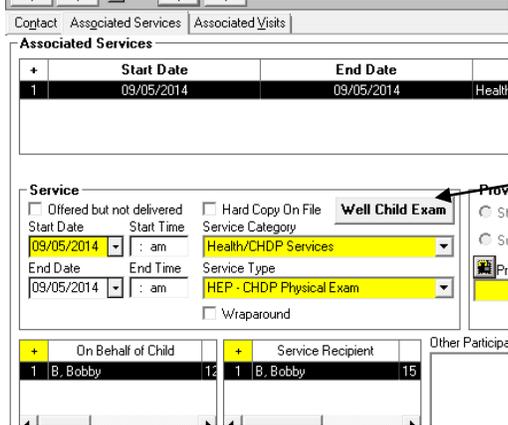
There is no phonetic search – that means that your spelling has to be just right, or you will not find the provider.

Narrow the search by including City or Zip Code.

Use the 'Wild Card' for additional search power.

Example: Searching for the provider Financial First: surround the word 'financial' with the percent (%) signs – any provider with the word financial in it will be added to the Provider Name drop down list.

The first 50 providers will be displayed in the search, but there will be a message telling you there are more than 50. You must enter additional search parameters in order to view more.

<p>CREATE NEW SERVICE PROVIDER: **Only if you were unable to locate provider using SEARCH**</p> 	<p>To create a new service provider in the database:</p> <p>Click on the + under the Cornucopia</p> <p>Complete both Name (Clinic name preferred) and Address tabs with as much information as you can.</p> <p>Be sure to complete all YELLOW fields.</p>
	<p>After the Service Provider is added to the Associated Services tab:</p> <p>Click on Well Child Exam stereo button to open Medical/Dental Referral field then enter exam info (this info will then populate to the Health Notebook and HEP)</p> <ul style="list-style-type: none"> Information added to the Narrative field of the Associated Services tab will not populate to the Health Notebook and HEP

Recording Authorizations for the Use of Psychotropic Medications in the Health Notebook

Outcome Measure 5F; this measure provides the percent of children in foster care with a court order or parental consent that authorizes the child to receive psychotropic medication.

Diagnosed Condition Tab



Client Services - Case [Brady, Bobby] - [Health [Bobby Brady]] You are currently running Scenario Manager.

File Edit Search Action Associated Attach/Detach Window Help Tools

Summary Diagnosed Condition Observed Condition Medications Hospitalizations Medical Tests Referrals Immunization Well Child Birth History

Diagnosed Condition

#	Alert	Health Problem	Diagnosed By	Onset Date / First Visit	End Date
1	Yes	Attention Deficit Hyperactive Disorder	Dr. Kildare	02/04/2008	

Alert

Onset Date/First Visit: 02/04/2008

End Date: [] Next Scheduled Visit Date: []

Diagnosed By

Name: Dr. Kildare Phone: [] - []

Condition

Category: Emotional

Health Problem: Attention Deficit Hyperactive Disorder

Communicable Disease

Unknown No Yes

For This Diagnosed Condition

Medications Prescribed

Unknown No Yes

Medical Tests Ordered

Unknown No Yes

Hospitalizations Occurred

Unknown No Yes

Referrals Made

Unknown No Yes

Health Problem Description

Treatment Plan / Instructions

Ready Case [Brady, Bobby] -> Client [] -> Health [Bobby Brady]

- ✓ Onset Date = Date condition was diagnosed by practitioner. This could be before or after child entered foster care.
- ✓ Health Problem = Choose the most appropriate health problem, **avoid** using Psychotropic Medication required.
- ✓ Health Problem Description = Add the condition as written on the JV220.

Medications Tab



Client Services - Case [Brady, Bobby] - [Health [Bobby Brady]]

File Edit Search Action Associated Attach/Detach Window Help Toolz

Summary | Diagnosed Condition | Observed Condition | Medications | Hospitalizations | Medical Tests | Referrals | Immunization | Well Child | Birth History

+	Alert	Prescribed Medication	Start Date	End Date
1	Yes	Ritalin	02/04/2008	

Client Condition: Attention Deficit Hyperactive Disorder

Onset Date / First Visit: 02/04/2008

End Date:

Prescribed Medication: Ritalin

Prescribed By: Dr. Kildare

Start Date: 02/04/2008

Projected End Date: 08/08/2009

End Date:

Comment / Instructions:

is this a psychotropic medication?
 Yes No

Is this medication administered for psychiatric reasons?
 Yes No

Parental Consent/Court Order

+	Consent Type	Date
1	Court Ordered	02/08/2008

Consent Type: Parental Consent Court Ordered

Date: 02/08/2008

Ready Case [Brady, Bobby] -> Client [] -> Health [Bobby Brady]

No End Date

Parental
Consent/Court
Order date here

One medication per line:

- ✓ Prescribed Medication is attached to the diagnosed condition it has been prescribed for.
- ✓ Prescribed By = enter the doctor that prescribed the medication.
- ✓ Start date = with **NO** end date indicates current medication. Use the actual date child begins taking the medication.
- ✓ Projected End Date = Date the court order expires (should be 6 months/180 days from date of current court order).

- ✓ End Date = **Only** use this to record a medication that the child is no longer taking or if the JV220 has expired.
- ✓ Court Ordered Date = Date JV220 is signed by the judge. **Update** this date as new court order is signed for current medication – add a new row with new date.
- ✓ Comment/Instructions:
 - Date each entry
 - List the dosage or range
 - List alternative medications listed on the JV220 that may be given in the future
 - If medication is same, but new doctor – note here and Prescribed By field
- ✓ Check appropriate radio buttons if the medication is 'psychotropic' and if administered for 'psychiatric purposes'.
- ✓ Click on + then designate if psych meds are approved by parental consent or court order

One medication listed on this page must be Active – no end date unless the JV220 for all psychotropic meds has expired. Or the medication must have been active during the review period. A Psychotropic Medication consent date must have occurred prior to the last day of the review period – either Court Order or Parental Consent date.

Screenings Page

The [Child Abuse Prevention and Treatment Act \(CAPTA\) 2010](#) require screening, evaluation, and referral for early intervention services for children under 3 with a substantiated allegation. In addition, CDSS must ensure that children of all ages in foster care or at risk of foster care placement are screened for mental health issues and developmental delays, and in 2007 the CDSS initiated a multi-agency effort to reach those goals.

Screenings				
+	Date	Type	Screened By	Results
Date	Type	Screened By		Results
<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="radio"/> Referral for Services <input type="radio"/> No Referral Needed
Comments				

- *Date* – The date the screening occurred. Future dates will not be allowed.
- *Type* – The type of screening that occurred. Users can select from a list of ten values. If one of the “N/A – Receiving Services” values is selected, the *Screened By* and *Results* fields will be disabled.

Type of Screening values:

- Initial Developmental 0-3 Years Old
- Initial Developmental 3+ Years Old
- Initial Mental Health 0-5 Years Old
- Initial Mental Health 5+ Years Old
- N/A – Receiving Developmental Services
- N/A – Receiving MHSs
- Updated Developmental 0-3 Years Old
- Updated Developmental 3+ Years Old
- Updated Mental Health 0-5 Years Old
- Updated Mental Health 5+ Years Old

- *Screened By* – The type of professional who performed the screening. Users can select from a list of eight values.

Screened By values:

- Staff Person
- Caregiver
- Service Provider
- Early Start Professional
- Mental Health Professional
- Health Care Provider

- Regional Center
- Public Health Nurse
- *Results* – This is the result of the screening, available choices are ‘Referral for Services’ or ‘No Referral Needed’. This field will not be enabled until *Date*, *Type*, and *Screened By* have been entered.
- The grid will be sorted by *Date*, with the most recent rows at the top.
- *Date* and *Type* are mandatory for creating a new row.

Referrals				
+	Referral Date	Referral Type	Referred To	
Referral Date	Referral Type	Referred To	<input type="checkbox"/> Out of County	Comments
<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>
Outcome of Referral		Outcome Date	Consent Type	Consent on File Date
<input type="radio"/> Accepted <input type="radio"/> Not Accepted		<input type="text"/>	<input type="text"/>	<input type="text"/>

- *Referral Date* – The date the referral was made. Future dates will not be allowed.
- *Referral Type* – The type of referral made, either ‘Developmental’ or ‘Mental Health’.
- *Referred To* - This is who the referral was sent to. Users can select from a list of five values.

Referred To values:

- Regional Center
- County Mental Health
- Service Provider
- Local Educational Agency
- Early Start
- *Out of County* – Used to indicate that the referral was sent to another county. This field is enabled after a *Referred To* value has been selected.
- *Outcome of Referral* – This is the result of the referral, available choices are ‘Accepted’ or ‘Not Accepted’.
- *Outcome Date* – This is the date that a decision was made whether or not to accept the referral. This field is enabled after an *Outcome of Referral* value has been selected.

Future dates will not be allowed, and this date must be greater than or equal to the *Referral Date*.

- *Consent Type* – This is the type of consent that was given to allow the referral. Users can select from a list of nine values.

Consent Type values:

- Parent/Legal Guardian
- Court
- Child 12 and older
- Consent Denied
- Consent Revoked
- Non-Minor Dependent (NMD)
- Educational Rights (IFSP)
- Early Start Surrogate Parent
- PPLA Relative Caregiver

- *Consent on File Date* – This is the date that the consent was received. Future dates will not be allowed.
- The grid will be sorted by *Referral Date*, with the most recent rows at the top.
- *Referral Date*, *Referral Type*, and *Referred To* are mandatory for creating a new row.

Intervention Plan				
+	Start Date	Plan Type	End Reason	End Date
Start Date	Plan Type	Comments		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
End Reason	End Date			
<input type="text"/>	<input type="text"/>			

When an Intervention Plan is created, at least one of the *Recommended Intervention Choices* must be selected.

- The *Start Date* of a *Recommended Intervention Choice* must be greater than or equal to the *Start Date* of the associated Intervention Plan. The *End Date* of a *Recommended Intervention Choice* must be less than or equal to the *End Date* of the associated Intervention Plan.

- *Start Date* – The starting date of the Intervention Plan. No future dates will be allowed.
- *Plan Type* – The type of Intervention Plan that is being created. Four choices will be available, 'Initial – Mental Health', 'Updated – Mental Health', 'Initial – Developmental', and 'Updated – Developmental'.
- *End Reason* – The reason for ending the Intervention Plan. Users can select from a list of twelve values. If an End Reason is entered, an End Date becomes mandatory.

End Reason values:

- Goals Met
 - Sufficient Progress Achieved
 - Change of Jurisdiction
 - 300 Court Case Dismissed
 - 600 Court Case Dismissed
 - Voluntary Closure
 - Child Runaway
 - Child Moved out of County
 - Incarcerated
 - Hospitalized
 - Consent Revoked/Refused
 - Deceased
-
- End Date – The ending date of the Intervention Plan. If an End Date is entered, an End Reason becomes mandatory.
 - The Intervention Plan grid will be sorted with active plans at the top. The ended plans will be sorted by *End Date*, with the most recently ended appearing nearer to the top.
 - *Start Date*, *Plan Type*, and entry of at least one of the *Recommended Intervention Choices* are mandatory when creating a new row.

Plan Detail			
+	Start Date	Recommended Intervention Choices	End Date
Start Date	Recommended Intervention Choices	End Date	Comments
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

- Start Date – The starting date of the *Recommended Intervention Choice*. Future dates will be allowed.
- Recommended Intervention Choices – A list of available components of an Intervention Plan.

Recommended Intervention Choices values:

- Child and Family Team - Both
- Community Based Services - Both
- Crisis Intervention – MH
- Early Intervention Services/IFSP - DD
- Inpatient Treatment - MH
- Intensive Care Coordination - MH
- Intensive Home Based Services - MH
- Outpatient Treatment - MH
- Treatment Foster Care - MH
- Communication - DD
- Gross/Fine Motor - DD
- Cognitive - DD
- Social Emotional - Both
- Adaptive - DD
- Natural Supports - DD
- Medication Support Services - MH
- Therapeutic Behavioral Services – MH
- Assessment - Both
- Other – Both

Key: MH – Mental Health DD – Developmental Both – Both MH and DD *Note – These indicators (MH/DD/Both) will not appear in CWS/CMS.

- End Date – The ending date of the *Recommended Intervention Choice*. Future dates will be allowed. This field is mandatory if the associated Intervention Plan End Date is populated.
- The Plan Detail grid will be sorted with active choices at the top. The end dated choices will be sorted by *End Date*, with the most recently ended nearer to the top.
- *Start Date*, and *Recommended Intervention Choices* are mandatory for creating a new row.
- If 'Other' is selected from the *Recommended Intervention Choices*, the *Comments* field becomes mandatory.
- The available *Recommended Intervention Choices* will be determined by the *Plan Type* that was chosen.

****PNSP: Placement Needs and Services Plan/Individual Health Plan is a document that includes a summary the child's case plan as well as medical status that may be used as a communication tool between the courts, SWs/POs, SCPs and PHNs.**

Section 6-----Behavioral and Mental Health

Background

Welfare & Institution Code (W&IC), Article 2, Section 5852 Interagency system of care; establishment:

In 1983 the State Department of Mental Health established an interagency system of care for children with serious emotional and behavioral disturbances to provide them with comprehensive and coordinated services.

Welfare & Institution Codes that apply:

- W&IC Article 3: Section 5856 & 5856.2 Target Population
- W&IC Article 6: Section 5865.1, 5865.3, 5866, 5867.5 County System of Care Requirements
- W&IC Article 7: Section 5868 County Service Standards. Establishment of Standards; Components; Responsibilities of Case Manager
- W&IC Article 8 State Department of Mental Health Requirements

California Code of Regulations, Section: 1810.247 Specialty Mental Health Services:

- Shall be provided to Medi-Cal beneficiaries (beneficiary certified as eligible under Medi-Cal program) of each county through a mental health plan which contracts with the County Child Welfare Department to provide specialty mental health services to Medi-Cal beneficiaries.

2011 Public Law 112-34:

The Child and Family Services Improvement and Innovation Act of 2011 (Public Law 112-34) requires State Title IV-B agencies to improve the oversight and monitoring of psychotropic medication and to include as part of their Health Care Coordination and Oversight Plan comprehensive description of protocols planned to ensure the safe and appropriate use of these medications. California law (Welfare and Institutions Code sections 369.5 and 739.5) requires juvenile court authorization prior to the administration of psychotropic medications to children and youth in foster care. The Psychotropic Medication Protocol, also referred to as the JV220 process, initiates the

court authorization of psychotropic medications for dependents of the court. While this process provides a certain level of oversight of psychotropic medication use by children in foster care, additional steps are needed to ensure optimal safety and a more effective delivery of mental health services to these children in care. (All County Information Notice I-36-15)

CAPTA 2010: Developmental and Mental Health Screenings for Children Three years and younger

There has been additional legislation, providing funding and mandating that children in out of home placement, 3 years and younger, receive developmental screenings. See local CWS agency for guidance regarding specific policies and procedures regarding the input of this data into the CWS/CMS system. Child Abuse Prevention and Treatment Act ([Public Law 93-247](#)),(CAPTA 2010).

Developmental or mental health screenings can be entered under the Screening tab in the Health Notebook (See the CWS/CMS section).

Specialty Mental Health Services are defined as:

- ❖ Rehabilitative Mental Health Services, including:
 - MHSs
 - Medication support services
 - Day treatment intensive
 - Day rehabilitation
 - Crisis intervention
 - Crisis stabilization
 - Adult residential treatment services
 - Crisis residential treatment services
 - Psychiatric health facility services
 - Psychiatric Inpatient Hospital Services
 - Targeted Case Management
 - Psychiatrist Services
 - Psychologist Services

- EPSDT Supplemental Specialty Mental Health Services
- Psychiatric Nursing Facility Services

- ❖ MHSs provided to Children in Out-of-Home Placement living in County-of-Origin include:
 - Individual or group therapies and interventions that are designed to provide reduction of mental disability
 - Restoration, improvement or maintenance of functioning consistent with the goals of learning and development
 - Independent living skills and enhanced self-sufficiency
 - Service activities may include but are not limited to:
 - Assessment
 - Plan Development
 - Therapy & Rehabilitation
 - Collateral (service activities provided to a significant support person in the beneficiary's life)

- ❖ MHSs for children detained in Out-of-Home Placement but Living Out-of-County of Origin (Host County)

On October 11, 2007, Senate Bill (SB) 785 was approved by the Governor of CA. The intent of the Bill was to facilitate the timely receipt of necessary MHSs for children living out of their County-of-Origin (Host County) in:

- Foster Care
- Adoption Assistance Program (AAP)
- Kin-GAP children

SB 785 impact on Medi-Cal Eligible Foster Children in Out-of-County Placement (Host County)

- The Mental Health Plan (MHP) in the child's County-of-Origin is responsible for providing or arranging for medically necessary specialty MHSs for children residing outside their County-of-Origin

- Defines County-of-Origin and Host County (Placement County).
 - County-of-Origin: the county where legal jurisdiction has been established and/or that has financial responsibility for the child or youth.
 - Host County: The County in which a child resides outside of the County that has legal jurisdiction for that child.

- Requires that for children in AAP and Kin-GAP programs, the host county submits the treatment authorization request (TAR) or Service Authorization Request (SAR) to the county of origin. Once the authorization is received the host county assumes responsibility for the provision of services.
 - The County-of-Origin has three (3) working days from the date of receipt of the TAR to make an authorization decision
 - The County-of-Origin may request additional information, but must make the authorization decision within three (3) days of receipt of the additional information. The authorization decision must be made within 14 days of the receipt of the TAR

Mental Health Managed Care Realignment

On July 1, 2011, state funds were realigned to the counties for Mental Health Managed Care, including EPSDT medically necessary MHSs.

The state will be providing: Oversight to assure Counties are providing medically necessary MHSs to children on Medi-Cal, including children and youth in foster care

The Mental Health Services Division, MHSD Information No. 13-01 reminds the MHP about their responsibility to provide Specialty Mental Health Services to Medi-Cal beneficiaries.

As of January 2014, Medi-Cal Managed Care Plans have taken over the provision of certain mental health and substance use related services.

- This may result in changes in the delivery of service for foster youth with low to moderate level behavioral health needs
- Services may require referral through an Administrative Services Organization, such as Beacon or Value Options
- Processes will vary from County to County

Katie A Settlement

In late 2011, additional intensive oversight for ensuring the provision of appropriate community-based MHSs was given to the subclass of youth who are in, or at imminent risk of entering, foster care in California.

Link to Katie A website:

www.lacdcfs.org/KatieA/index.html

Link to State of California Katie A website:

<http://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx>

Note: HCPCFC PHN attendance may be required at Child/Family Team meetings (TDM) for children receiving these services. Check with your County's Policy & Procedure Practice Guide

HCPCFC PHN Role and Responsibilities

The role of the HCPCFC PHN is to facilitate and support the child's assigned case manager to gain access to MHSs. The health needs of a child in out-of-home placement include the child's mental wellbeing.

PHN will:

- Assist the case manager with linkages/access to MHS:
- In County (County of Origin)
- Out- of- County (Host County)

- Consult with the prescribing psychiatrist, primary care physician, case manager to assist in:
 - Ensuring that every child in out-of-home placement has a current record of prescribed psychotropic medication documented in the HEP as records are made available from the case manager

According to the California Department of Social Services (CDSS) and California Department of Health Care Services (DHCS) policy, the case manager will ensure that the psychotropic medication order is renewed every six months or as needed with support from the HCPCFC PHN.

Navigation of Mental Health Services

Process to Obtain Specialty Mental Health Services for a Child Placed in County-of-Origin

The case manager should:

- call the County-of-Origin's Mental Health Plan ACCESS or INTAKE Unit to coordinate MHSs.
- follow-up within a few days to see what action has occurred.

Process to Obtain Specialty Mental Health Services for a Child Placed Out of County.

The case manager should:

- call the County of Origin's Mental Health Plan ACCESS or INTAKE Unit to coordinate MHSs in the Host County OR use the County's Mental Health Plan Foster Youth Referral Form
- Provide the youth's demographic information (name, date of birth, Medi-Cal #).
- follow-up within a few days to see what action has occurred.

County of Origin provides the necessary TAR or SAR to the host county.

TAR/SAR needs to be renewed every 6 months or up to one year, depending on the county's policy, with the exception of AAP/KinGAP (SB 785, CCR Title 9).

If the County of Origin is having problems in obtaining MHS in the Host County, the Mental Health Ombudsman should be called at 1-800-896-4042. The Ombudsman's e-mail is: mhombudsman@dhcs.ca.gov

Medi-Cal eligibility issues that impact obtaining MHS

- Relative's home does not qualify for Federal Foster Care funding:
When a foster child is placed in a relative home and does not qualify for federal foster care funding the relative/s should apply for CalWORKs and/or Medi-Cal for the foster child (4H or 4L Medi-Cal aid code) as a Non-needy Relative. The Non-Needy Program only aids the FC Child.

The child will receive MHSs from their county of residence. Foster youth on SSI (60 Medi-Cal aid code) will receive their MHSs from their county of residence or host county.

Medi-Cal Eligibility Verification Computer System:

Aid Codes identify the type of Medi-Cal or Public Health Program & Services recipients are eligible to receive.

Navigation of Specialty Mental Health Services

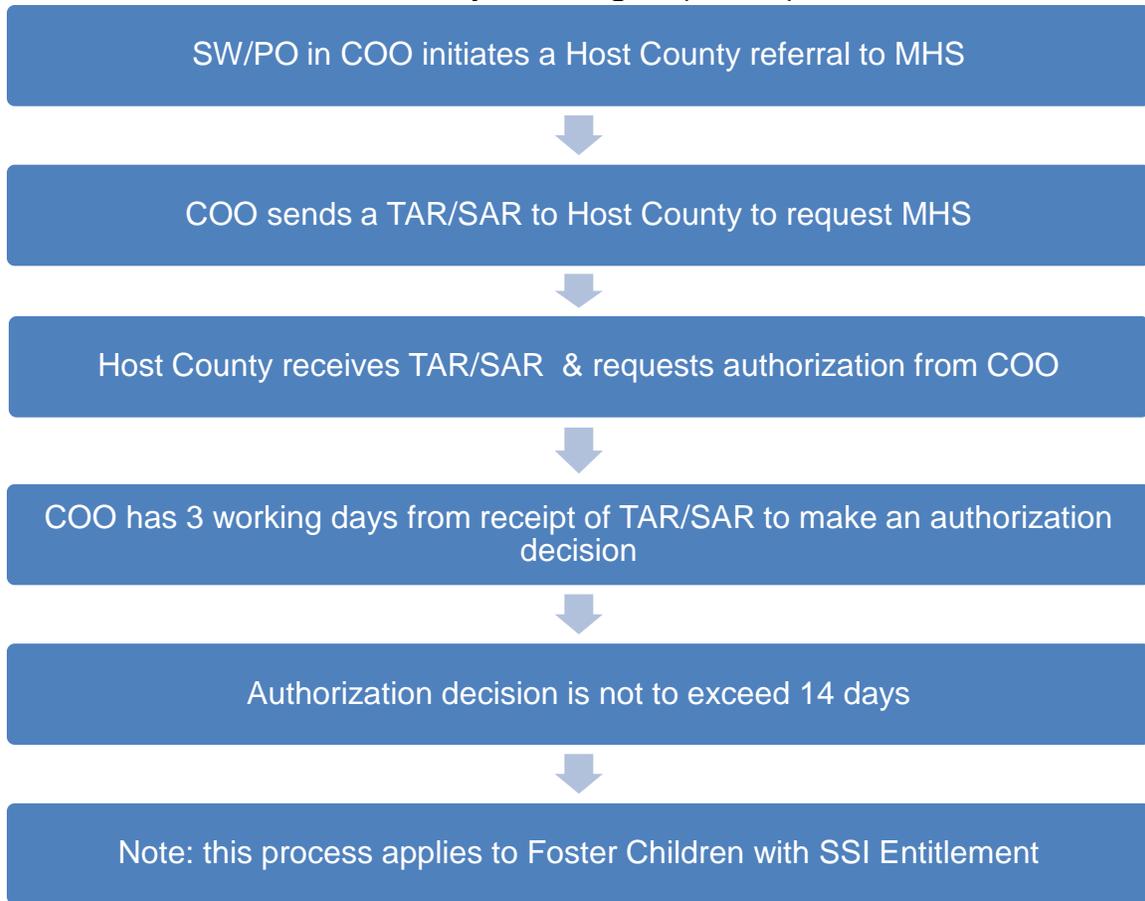
In County services

Out of county services

Out of county services – Kin-GAP/AAP

Navigating Specialty Mental Health Services (MHS) for Foster Children in Out-of-County (Host County) Placement

County of Origin (COO)



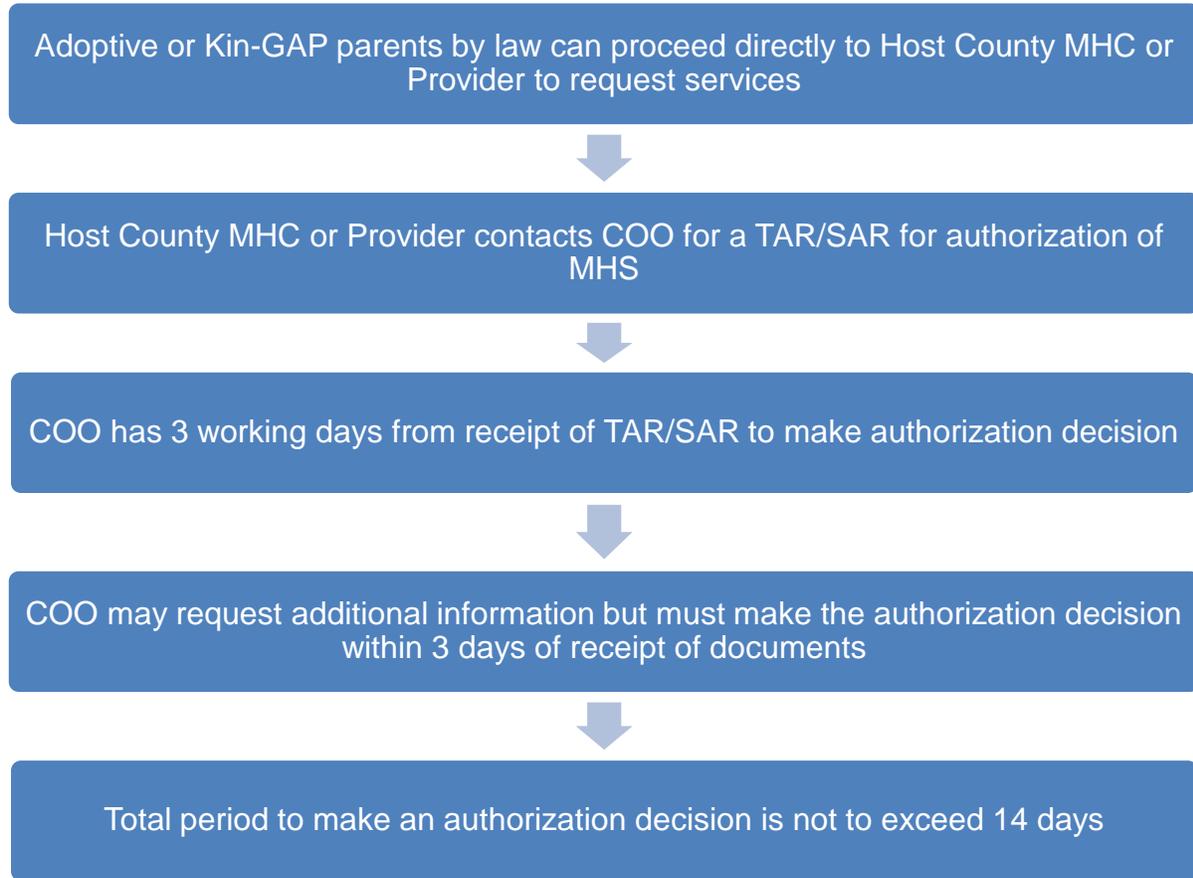
Note: Refer to your County Policy & Procedure/Practice Guide for specific information on how your County processes Mental Health Services.

- ❖ For further assistance contact: **State Mental Health Ombudsman @1-800-896-4042**
- ❖ References: SB 785, CCR Title 9
- ❖ State has oversight for mental health services for children on Medi-Cal, including foster children

Legend
County of Origin (COO): County of Jurisdiction
Host County (HC): Placement County
SW: Social Worker
PO: Probation Officer

Navigating Specialty Mental Health Services (MHS) for Foster Children in Out-of-County (Host County) Placement

AAP/Kin-GAP



Note: Refer to your County Policy & Procedure/Practice Guide for specific information on how your County processes Mental Health Services.

- ❖ **For further assistance contact: State Mental Health Ombudsman @1-800-896-4042**
- ❖ References: SB 785, CCR Title 9
- ❖ State has oversight for mental health services for children on Medi-Cal, including foster children

Legend

AAP: Adoption Assistance Program

County of Origin (COO): County of Jurisdiction

Host County (HC): Placement County

SW: Social Worker

PO: Probation Officer

MHC: Mental Health Clinic

Psychotropic Medication Guidelines

“The term psychotropic medication means those medications prescribed that affect the central nervous system and treat psychiatric disorders or illnesses. They may include, but are not limited to: anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, psycho stimulants, and medications for dementia.” [CA Rules of Court 5.640\(a\)](#)

Authorization of Psychotropic Medications (JV-220)

[\(Welfare and Institutions Code §369.5; §739.5\)](#) [\(CA Rules of Court 5.640\)](#)

Once a child is declared a dependent of the State or delinquent in juvenile court, and is removed from the custody of the parents or guardian, only a juvenile court judicial officer is authorized to sign orders consenting for the administration of psychotropic medication. A parent can consent in instances when they retain the right to make medical decisions. The forms used during the process to obtain the courts' permission include the [JV-219](#), [JV-220](#), [JV-220\(A\)](#), [JV-221](#), [JV-222](#) and [JV-223](#). Documenting the Court's consent in CWS/CMS is important to communicate health history and assist the foster care team with assessing, planning and evaluating the plan of care for the child. There may be additional activities related to psychotropic medication oversight and monitoring based on the statewide quality improvement project: “[Improving the Use of Psychotropic Medications in Children and Youth in Foster Care](#)” and Katie A Settlement implementation

Current Psychotropic Medication Quality Improvement Project

On December 14, 2011, the United States Governmental Accountability Office (GAO) published a report, GAO-12-201, “Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions.” Recommendation:

The Federal Department of Health and Human Services (HHS) can provide guidance to states on best practices for the oversight of psychotropic medication use for children in foster care. A nationwide kickoff of this project began October 2012 in Washington D.C.

The State of California Department of Health Care Services (DHCS)/California Department of Social Services (CDSS) partnered and began a three year quality improvement (QI) project, *“Improving the Use of Psychotropic Medications in Children and Youth in Foster Care”* to address quality issues, such as:

- Prescribing excessively to those of young age or before alternatives were tried (too soon)
- Prescribing multiple medications (too many)
- Prescribing too high a dosage (too much)
- Prescribing for indefinite periods without adequate review of benefit (too long)

For information regarding the updated guidelines for psychotropic medication in California and the Parameters for use of Psychotropic Medication in Children and Adolescents please access the following links:

- [California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care](#)
- [Department of Mental Health Parameters 3.8 for Use of Psychotropic Medication in Children and Adolescents](#)

Psychotropic Medication Authorization (PMA) Process

(JV219 through JV223) (W&IC §369.5; §739.5) (CA Rules of Court 5.640)

Forms:

JV-219

List of the forms to be complete:

- Application
- Order
- Proof of Notice
- Opposition to Psychotropic Medication
- Detailed information on how to apply for psychotropic medication
- JV-220 Application Regarding Psychotropic Medication

- JV-220(A) Prescribing Physician's Statement - Attachment
- JV-221 Proof of Notice: Application Regarding Psychotropic Medication
- JV-223 Order Regarding Application for Psychotropic Medication
- JV-222 Opposition to Application Regarding Psychotropic Medication should be submitted only in the event that a party is opposing the Order of Psychotropic Medication

Use of the forms is not required if the child is a Dependent under Family Maintenance Services (and the parent agrees with the request) or if the Court has entered an order giving the child's parent the authority to approve or deny the administration of psychotropic medication to the child.

NOTE: Refer to your County's Policy & Procedure Practice Guide for specific instructions on how Psychotropic Medication Orders are processed.

Documentation of PMA in the Health and Education Passport

DOCUMENTING THE AUTHORIZED PSYCHOTROPIC MEDICATIONS ORDER IN THE CWS/CMS HEALTH NOTEBOOK

DIAGNOSED CONDITION Page:



Mandatory Yellow Fields:

Onset Date:

- Date condition was diagnosed by Mental Health practitioner
- This could be before or after child entered foster care

Condition/Health Problem:

- Choose the most appropriate Mental Health condition

Health Problem Description:

- Add the condition as written on the JV220

Treatment Plan/Instructions:

- Add a basic description of the treatment plan (Ex: Individual Therapy & Medication)

Alert	Health Problem	Diagnosed By	Onset Date / First Visit	End Date
1 Yes	Attention Deficit Hyperactive Disorder	Dr. Kildare	02/04/2008	

Alert Onset Date/First Visit: 02/04/2008
 End Date: Next Scheduled Visit Date:

Diagnosed By
 Name: Dr. Kildare Phone: () -

Condition
 Category: Emotional
 Health Problem: Attention Deficit Hyperactive Disorder
 Communicable Disease: No Yes

For This Diagnosed Condition
 Medications Prescribed: Unknown No Yes
 Hospitalizations Occurred: Unknown No Yes
 Medical Tests Ordered: Unknown No Yes
 Referrals Made: Unknown No Yes

Health Problem Description

Treatment Plan / Instructions

EXAMPLE: Ready Case [Brady, Bobby] -> Client [] -> Health [Bobby Brady]

MEDICATIONS Page:



Mandatory Yellow Fields (Enter one medication per line)

Prescribed medication:

- Correlates to the Diagnosed Condition

Prescribed by:

- Enter the doctor that prescribed the medication

Start date:

- Date the judge signs the JV223

Projected End Date:

- Date the court order expires (should be 6 months/180 days from date of current court order)

End Date:

- Only use this to record a medication that the child is no longer taking or JV 220 has expired

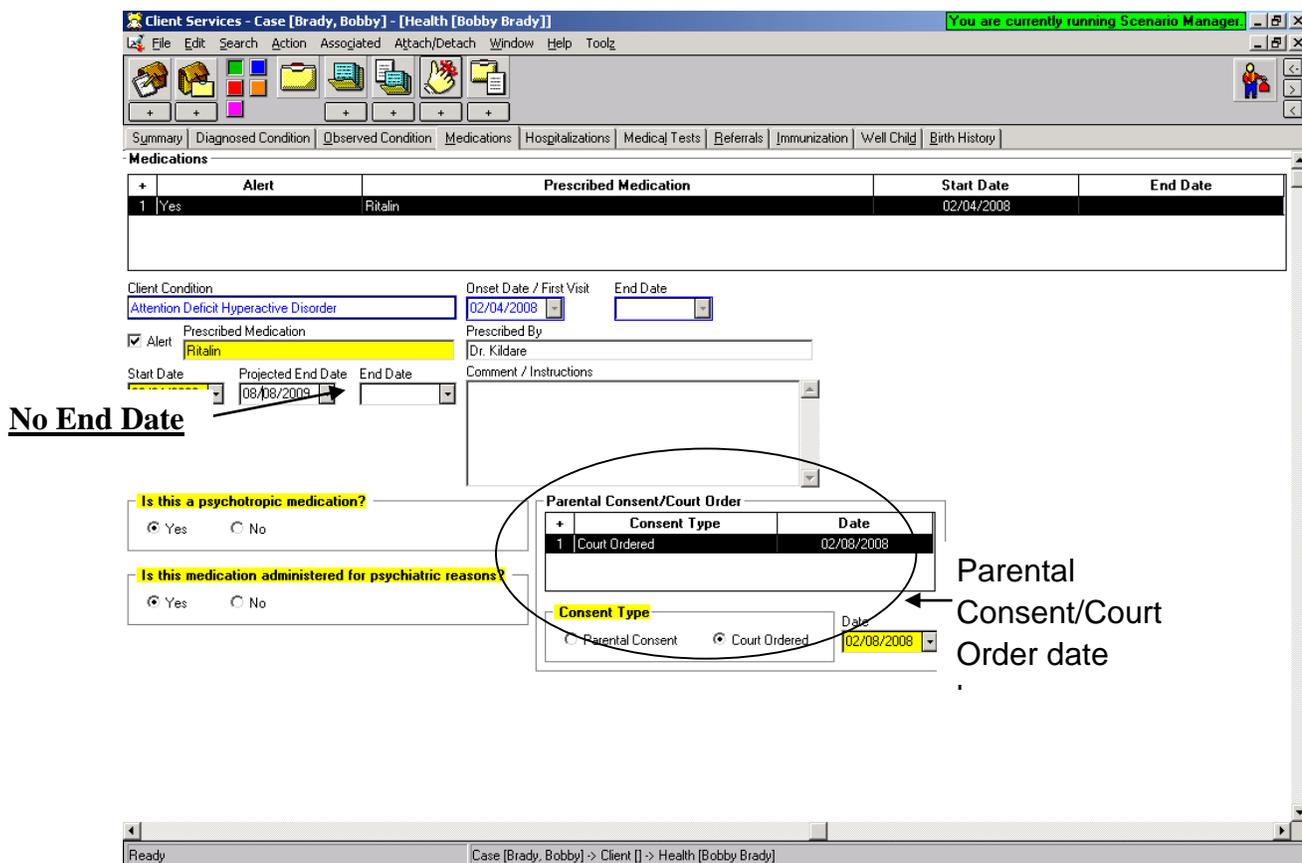
Court Ordered Date:

- Date the JV223 is signed by the judge
- Update this date as new court order is signed for current, continuing medication

Comment/Instructions:

- List the administration instructions/schedule
- List the maximum total mg/day (dosage or range)
- List the symptoms targeted by the medication
- List the treatment duration
- List alternative medications listed on the JV220 that may be given in the future

Example:



Frequently Asked Questions

Q: When is an authorization for psychotropic medication needed?

A: Court authorization for psychotropic medication is required for all:

- Children declared dependents of the Court & in out-of-home placement
- Children for whom a dependency petition is pending
- Jurisdiction hearing has not taken place
- There is no existing Court Order approving psychotropic medication
- Parent cannot be found to sign a Consent for administration of the medication

Q: Who may authorize psychotropic medication?

A:

1. The Juvenile Court has exclusive authority to authorize the administration of psychotropic medication for Dependent children in out-of-home placement.

- Per [CA Rules of Court 5.640\(e\)](#), after consideration of an application and attachments and a review of the case file, the Court may order that the parent be authorized to approve or deny the administration of psychotropic medication.
- A Court order to grant this authority must be based on the findings that the parent:
 - Poses no danger to the child
 - Has the capacity to understand the request and the information provided.
 - Has the capacity to authorize medications in the best interest of the child.

2. When do parents/guardians have authority to consent to psychotropic medication:

The parent or legal guardian may consent to the administration of psychotropic medication for a child who is:

- Temporarily detained, pending Court disposition and the establishment of dependency by the Court
- Dependent Children living with the parent or legal guardian receiving Family Maintenance Services

Q: Is Authorization Transferable?

A: Authorization for psychotropic medication, including the specific medication and the approved dosage range, is transferable to other physicians

- Includes in-patient physicians who care for the child during the period the authorization is in effect, regardless of whether the original physician is still providing care for the child

Note: A change in the child's placement does not require a new order regarding psychotropic medication as long as the medication and dosage remains the same.

Q: How frequently does the JV 220 have to be renewed?

A: All Court orders for psychotropic medication remain effective until terminated or modified by Court order or until 180 days from the date of the order, whichever is earlier. (Cal. Rule of Court 550.4(f))

Q: What are the notice requirements?

A: The law requires that, before the Court can authorize psychotropic medication for a Dependent, all parties must be given two (2) Court days to respond

- Opposition can be filed with the Court using the JV 222
- All parties must be notified sufficiently in advance to allow the required two (2) days to respond before the order is filed

Q: Is a JV 220 needed for Mental Health emergencies?

A: Pursuant to [W&IC 369\(d\)](#) and [Rules of Court 5.640\(g\)](#) psychotropic medication may be administered without Court authorization in an emergency situation.

1. An emergency situation occurs when:

- A physician finds that the child requires psychotropic medication to treat a psychiatric disorder or illness
- The purpose of the medication is:
 - To protect the life of the child or others
 - To prevent serious harm to the child or others
 - To treat current or imminent substantial suffering
 - It is impractical to obtain authorization from the Court before administering the psychotropic medication to the child

Note: Court authorization must be sought as soon as practical but in no case more than two Court days, after the emergency administration of the psychotropic medication.

Q: Who does the documentation of the completed psychotropic medication order?

A: After an order is signed for psychotropic medication:

- The nurse will enter the information into CWS/CMS
- Update the HEP
- Record must be updated to include the date of Judicial Consent as required by [W&IC section 369.5](#).

Note: Refer to your County Policy & Procedure/Practice Guide for specific information on how your County processes Mental Health Services.

Section 7-----Oral Health

Periodicity

Children in foster care are at moderate to high risk for dental disease and must receive a dental examination within 30 days of initial placement. After this visit, and completion of any necessary dental treatment, preventive visits are needed every six months. Refer to CHDP Provider Information Notice 11-10, Table 21.2 CHDP Periodicity Schedule for Dental Referral by Age, <http://www.dhcs.ca.gov/services/chdp/Documents/Letters/chdppin1110.pdf> .

Children with special health care needs can be at an even higher risk for poor oral health. Both home care and dental treatment may be particularly challenging. The child's dentist, in consultation with their medical provider(s), will determine if there is a need for more frequent visits.

Dental Health Information

The child's dental history may be obtained from various sources: the JV-225, "Your Child's Health and Education" (completed by the biological parent); other health questionnaires; and information from the case manager, primary care providers, and previous dental providers.

Information from the initial placement dental exam and routine follow-up exams can be obtained from dental provider notes or from health contact verification forms (see attached examples).

Documentation in the HEP

The routine periodic dental exam is documented in CWS/CMS under Contacts, much like the CHDP Well Child Exam, except that under the "Service Type" the option "HEP – Periodic Dental Exam" is chosen. (See "Creating Contacts, Entering Medical and Dental Exams", p. 3-____.) This documentation is necessary to track the periodic dental exam requirement for children in foster care.

The HCPCFC PHN or designated staff documents any identified problems or referrals in the narrative, and enters any provider-documented diagnosis and associated referral as needed.

Specialists Referrals

Children in foster care may be receiving or may be referred for specialized dental care (e.g., Pediatric Dentistry, Sedation/Hospital Dentistry, Oral Surgery, Orthodontics, Endodontics, Periodontics, etc.). Children needing specialized dental treatment require intensive care coordination to ensure completion of treatment.

Children with special health care needs will require intensive care coordination for both routine, as well as, specialized dental care. These children may not be able to tolerate, or may need extra precautions and close monitoring when receiving dental treatment. HCPCFC PHNs will need to encourage foster care parents to work together with dental providers to develop individual home care regimens.

Through consultation and collaboration, the HCPCFC PHN will connect the children to appropriate dental care and follow-up. It is important to identify barriers to care in order to facilitate diagnosis and treatment. Denti-Cal dental specialists may not be available in your county. The HCPCFC PHN may need to seek specialized dental treatment in another county. Some alternative resources for meeting this need can be found in the resource list below. Your local CHDP office may have additional resources.

Out of County Placements

For children placed out of county, the HCPCFC PHN may collaborate with the other county's HCPCFC PHNs to identify available providers and resources. The regional Foster Care Nurse Group is also a valuable tool to identify dental resources. All children in foster care are eligible for full scope fee-for-service Medi-Cal dental services (Denti-Cal). (Please note: Los Angeles and Sacramento Counties have managed care dental plans. Children who are enrolled in these plans are restricted to their assigned dental plan dentist. In order to see an out-of-county dentist, they will need to dis-enroll from their managed care dental plan.)

Resources

Denti-Cal Provider List

<http://www.denti-cal.ca.gov/WSI/Bene.jsp?fname=ProvReferral>

CHDP/HCPCFC Local Program Offices

<http://www.dhcs.ca.gov/services/chdp/Pages/CountyOffices.aspx>

California Children's Services (CCS) Local Program Offices

<http://www.dhcs.ca.gov/services/ccs/Pages/countyoffices.aspx>

ADA Dental Schools

<http://www.ada.org/en/home-ada/coda/find-a-program/search-dental-programs/dds-dmd-programs>

CDA Dental Society

<http://www.cda.org/about-cda/local-dental-societies>

Additional Information

Welfare Code 16501 (section a): Case plan must be in place within 60 days.

<http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=16001-17000&file=16500-16521.5>

AAP Pediatrics Health Care in Foster Care

<http://pediatrics.aappublications.org/content/109/3/536.full>

AAP Healthy Foster Care America

<http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Addressing-Barriers.aspx>

Table 21.2 CHDP PERIODICITY SCHEDULE FOR DENTAL REFERRAL BY AGE

Age (years)	12 Month Dental Referral	6 Month Dental Referral**
1* - 20	<p style="text-align: center;"><input checked="" type="checkbox"/></p> <p style="text-align: center;">Once a year <u>minimum</u></p>	<p style="text-align: center;"><input checked="" type="checkbox"/></p> <p style="text-align: center;">Most CHDP children are moderate to high caries risk. Refer every 6 months. *** Children with special needs may need more frequent referrals.</p>

- A dental screening/oral assessment is required at every CHDP health assessment regardless of age.
- Refer children directly to a dentist.
 - At least **annually** beginning at age one for maintenance of oral health (mandated beginning at age 3).
 - At any age if a problem is suspected or detected
 - Every six (6) months if moderate to high risk for caries
 - Every three (3) months for children with documented special health care needs when medical or oral condition can be affected
- To help find a dentist for a child with Medi-Cal, contact Denti-Cal at 1-800-322-6384 or <http://www.denti-cal.ca.gov>. For families with or without Medi-Cal, the local CHDP program can assist in finding a dentist.

* The American Academy of Pediatrics (AAP) policy recommendation is to establish a dental home by age one: <http://aappolicy.aappublications.org/cgi/abstract/pediatrics.122/6/1387.pdf>.

** For Medi-Cal eligible children, Denti-Cal will cover preventive services (exam, topical fluoride application, and prophylaxis) once in a six month period and more frequently if there is a documented necessity. Denti-Cal has adopted the American Academy of Pediatric Dentistry's (AAPD) "Recommendations for Preventive Pediatric Oral Health Care" which indicates frequencies for diagnostic and preventive procedures: http://www.denti-cal.ca.gov/provsnvcs/bulletins/Volume_26_Number_7.pdf. The AAPD emphasizes the importance of very early professional intervention and the continuity of care: http://www.aapd.org/medialPolicies/Guidelines/G_Periodicity.pdf

*** Caries Risk Factors for Early Childhood Caries: http://www.aap.org/commpeds/dochs/oralhealth/sect/ch4_sect7.cfm

References
 California Code of Regulations, Title 17, Subchapter 13, CHDP, Section 8943; Code of Federal Regulations, Title 42, Section 440.40 (b), Part 441, Subpart B. CHDP Program Letter, 04-13. Denti-Cal Bulletin Volume 26, Number 7, March 2010.

09-14-2011



Tehama County Department of Social Services

P. O. BOX 1515 • 310 S. MAIN STREET • RED BLUFF, CA 96080 530-527-1911

Charlene Reid, MSW, Director

CalWORKs/FS/MC ADULT SERVICES EMPLOYMENT SERVICES CHILD WELFARE SERVICE ADMINISTRATION
Fax (530) 527-5410 Fax (530) 527-4836 Fax (530) 527-5410 Fax (530) 527-7640 Fax (530) 527-2982

PARTNERING WITH OUR COMMUNITY TO ASSIST, EMPOWER AND PROTECT

Dental Care Follow-up Memo

Please provide the following information to Tehama County Department of Social Services, Child Welfare Services

Please check the following services that have been provided and return this form to our office.

Child's Name: _____ DOB: _____

- | Procedure | Date |
|---|--------------------|
| <input type="checkbox"/> General Check – up | _____ |
| <input type="checkbox"/> Dental X-rays | _____ |
| <input type="checkbox"/> Cleaning | _____ |
| <input type="checkbox"/> Fillings of _____ teeth. | _____ |
| <input type="checkbox"/> Sealants of _____ teeth. | _____ |
| <input type="checkbox"/> Other: _____ | _____ |
| <input type="checkbox"/> Work is complete | Yes _____ No _____ |
| <input type="checkbox"/> Additional appointments are needed | Yes _____ No _____ |

Dental Provider's Name: _____

Address: _____

Phone number: _____ Fax Number: _____

Signature of Dental Provider or representative _____

Next dental check due or dental referral made: _____

Thank you for providing this information. Please return this form by fax or mail to:

CWS Public Health Nurse, Tehama County Department of Social Services, Child Welfare Services,

PO Box 1515, Red Bluff, CA, 96080 or fax to 530-527-7640.

Please call Faith Cole, RN, PHN @ TCDSS Child Welfare Services if you have any questions at

phone number 530-528-4044.

DENTAL EXAM VERIFICATION FORM

Date: _____

Dentist / Dental Facility: _____ Phone: _____

Name of Child: _____ Date of Birth: _____

Last dental exam date: _____ Next dental exam due date: _____

Next scheduled appointment date: _____

**PLEASE TAKE THIS FORM TO THE NEXT DENTAL APPOINTMENT, AND
HAVE THE DENTIST VERIFY THE FOLLOWING:**

Dental Exam Completed Date: _____

___ Exam	___ X-Rays	___ Cleaning
___ Fillings	___ Sealants	___ Extractions
___ Other	_____	

Follow up treatment or referral recommended / scheduled:

Verified by: _____

Name / Signature

Date

PLEASE RETURN THIS FORM TO:

Jan Baza, Medical Services Clerk, Shasta County/Foster Care Nursing
1550 California St.
Redding, CA 96001 Fax: 530-229-8282

Section 8-----Navigating Medi-Cal

Medi-Cal -----is California's version of the federal Medicaid program.

This section will introduce you to Medi-Cal, [Foster Care Aid Codes](#), Medi-Cal Managed Care and information about [Kin-GAP and Adoption Assistance Program Benefits \(ACL11-86\)](#) including the expansion of the federal definition of a relative established by AB 1712 ([ACL 14-28](#)).

Presently, most children and youth within the foster care system are eligible for Full Benefits or Full Scope Medi-Cal with no Share of Cost (SOC). Most recently, through the federal Affordable Care Act of 2010, [young adults up to 26 years old](#) who were [in foster care at age 18, qualify for Full Benefits or Full Scope Medi-Cal with no SOC](#).

The Authority for Medi-Cal was enacted in federal law in 1965; Title IX of the Social Security Act was to provide needed [health care services](#) for low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women, and low income people with specific diseases ([DHCS Medi-Cal](#)). It is important to know that the Medi-Cal/Medicaid rules are changing and there are exceptions. It is important to understand the options for health care impacting the Medi-Cal population. The newest change, health care reform is based on two laws, the Patient Protection and the Affordable Act of 2010 and the Health Care and Education Reconciliation Act of 2010 referred to as the Affordable Care Act (ACA); in California it is provided through "[Covered California](#)". For more information about the ACA and it's potential impact on youth in out of home care, Georgetown University published [Foster Care Children and the Affordable Care Act – New Report from CCF and Community Catalyst](#) (July 24, 2012)

Every child in out of home care should have a medical home. When a child enters the dependency system, [Medi-Cal processing is expedited \(DHCS Letter 01-41\)](#) so the child can access services immediately. If there are delays in Medi-Cal processing, the Eligibility Worker (EW) and SW assigned to the child's case should be informed in order to address the delays. The nurse's knowledge of the health care system and resources will provide assistance to those involved in accessing health care services for the child.

Foster Care Aid Codes

[Aid codes](#) are used to identify the type of government aid or assistance (financial/Medi-Cal) a person is receiving. There are several aid codes common to foster care, including but not limited to 40, 42, 45, 4F, 4H 4L & 4M. As laws change, aid codes may be added to this list.

40, 42 & 45

These codes cover children on whose behalf financial assistance is provided respectively by, State, federal or other public funds for foster care placement.

4F – Kinship Guardianship Assistance Payment (Kin-GAP)

The 4F aid code covers children in the federal program for children in relative placement receiving cash assistance.

4H – CalWORKs Foster Care Medi-Cal ([ACL11-59](#))

The 4H aid code is used to identify FC Medi-Cal eligibility for children placed with relatives and receiving CalWORKs.

4L – [1931\(b\)](#) Foster Care ([ACL11-59](#))

The 4L aid code is used to identify FC Medi-Cal eligibility for children who are eligible for 1931(b) Medi-Cal and placed with relatives who may be receiving CalWORKs for themselves but not for the child. This aid code shall be used instead of aid code 3N for the foster children in a case.

4M - Former Foster Care Children [see \(Medi-Cal Eligibility Letter \[MEDIL\] 13-07\)](#)

Medi-Cal Managed Care Models

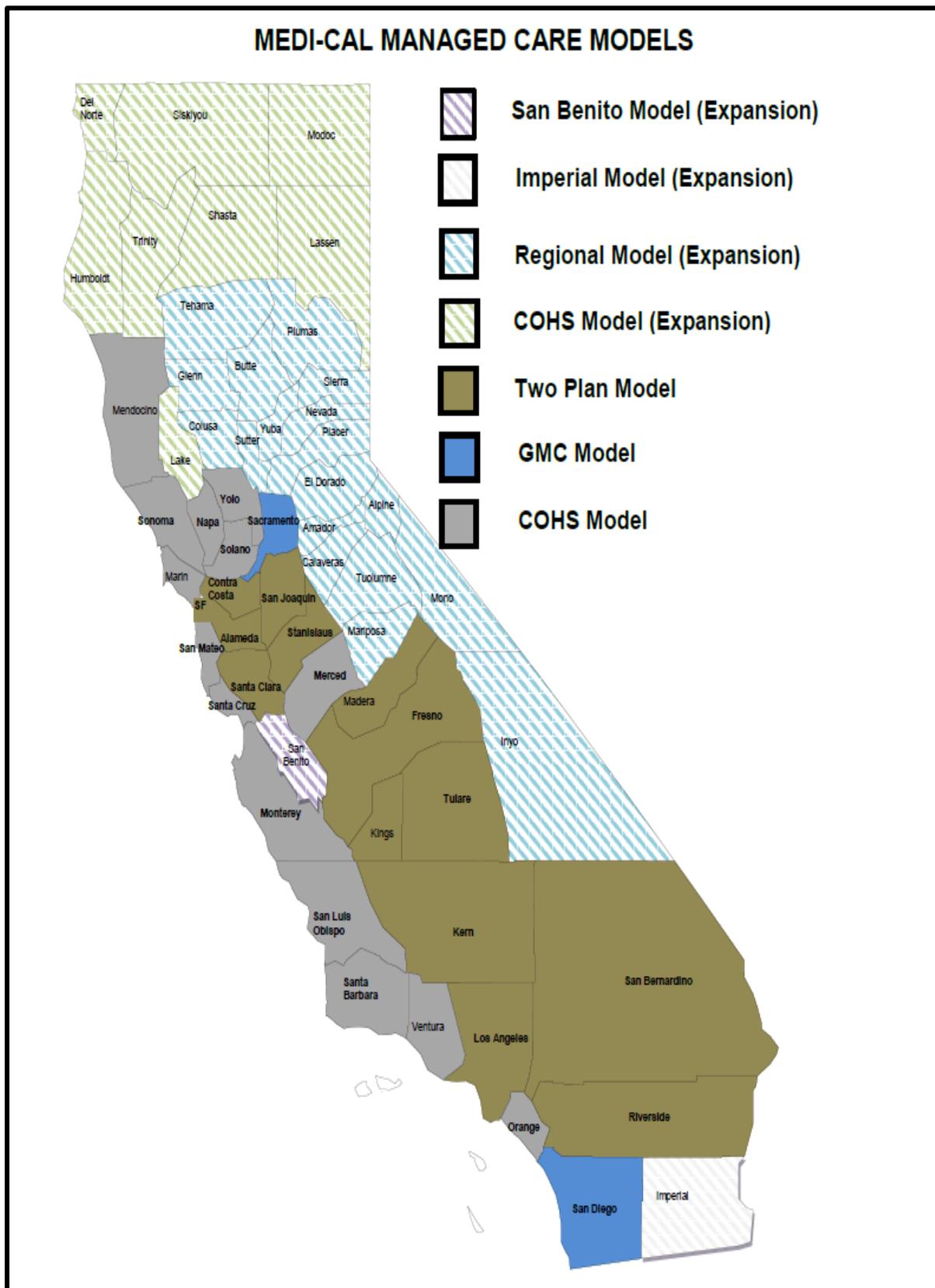
Throughout the state there are several counties providing fee-for-service or straight Medi-Cal (a child may go to any provider who accepts patients using Medi-Cal) for children in out of home care.

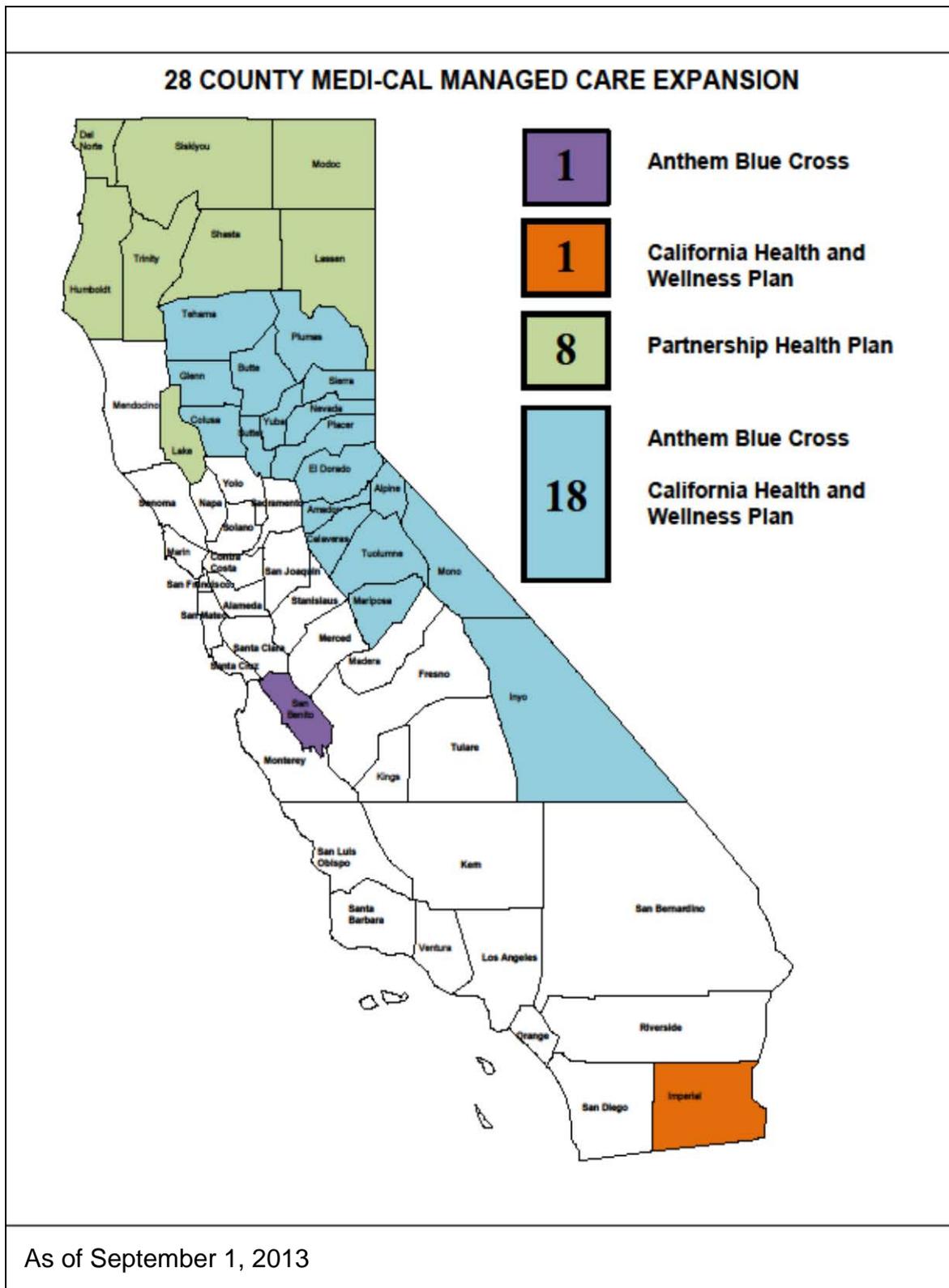
The remaining counties provide services through Medi-Cal Managed Care (MMC) plan services; there are three models for providing MMC:

- Two-Plan,
- County Organized Health Systems (COHS) and
- Geographic Managed Care (GMC)

A primary care provider must be selected and the plan notified for the child to receive care.

Below are maps of MMC plans by county. More information is available through the [Medi-Cal Managed Care Division \(MMCD\)](#). [Fact sheet for Managed Care Models in CA](#)





Challenges with Medi-Cal Managed Care

In the managed care environment, the assignment of a child in out-of-home placement to a primary care provider may present some difficulties. For children and youth transferring to different counties due to change in placement, the medical plan responsible for providing Medi-Cal services may change as well. For example, in Shasta County, the managed care entity Partnership Health Plan of CA (PHP) recognizes this reality, by granting children in foster care a “Special Member” status, allowing them to access healthcare at any provider who is willing to bill Partnership. The “Special Member” status is based on the child having a foster care aid code, but sometimes a phone call to PHP’s member services may be necessary to prompt an update in the child’s status.

Mental Health Services through Medi-Cal

[DHCS Mental Health Ombudsman for Medi-Cal issues](#): 1-800-896-4042

The [Department of Health Care Services \(DHCS\) administers MHSs](#) for children in out of home care across the state; check with your county for the specific mechanism it utilizes for referring and monitoring the provision of MHSs. There has been legislation to ensure appropriate MHSs are provided to youth active to CWS including:

[W&IC § 369.5](#): court or parental consent is required before a child in out of home care is allowed to take psychotropic medications.

[Katie A.](#): a lawsuit settlement which specifies the county/state is responsible for providing appropriate MHSs to youth active to CWS.

[Senate Bill \(SB\) 785](#): is intended to facilitate the receipt of medically necessary specialty mental health services by a [child in out of home care and placed outside of the county of jurisdiction](#); it also clarifies responsibility for treatment authorizations and transfers the responsibility for the provision of services to the host county while keeping the financial responsibility to authorize and pay for services remains with the county of jurisdiction.

The [Department of Mental Health \(DMH\) INFORMATION NOTICE NO.: 09-06](#) provides supplemental information instructions for the provision of MHSs for children in out of home care and placed outside of the county of jurisdiction.

The DHCS All Plan Letter ([APL 13-018](#)) provides information re: MEMORANDUM OF UNDERSTANDING REQUIREMENTS FOR MEDI-CAL MANAGED CARE PLANS to describe the responsibilities of Medi-Cal MCPs for amending or replacing MOU with the county MHPs for coordination of Medi-Cal MHSs.

Please see the Section III – Behavioral Health for further information.

Section 9 -----Miscellaneous

Special Health Care Needs

It is recognized that the child's case manager is ultimately responsible for addressing the child's educational, emotional, and medical needs, including special health care needs (SHCN). The HCPCFC PHN is one member of a multi-disciplinary team collaborating with the child's case manager, primary care doctor, medical specialists, and available resources within the community to meet the needs of the child. HCPCFC PHNs are in a unique position to be able to refer to and utilize community resources. Community resources may include Shriners Hospital, Easter Seals, and other charitable or community based organizations, Regional Centers, Early Intervention Services, CCS, Special Education Local Planning Area (SELPA), Field Public Health Nursing, Hospital Pediatric and Nursery Discharge Coordinators, Mental Health, School Nurses, Dentists specializing in the needs of children with SHCNs, HIV Programs, and Specialized In-Home Health Care Agencies.

Web links to the code sections named below may be found by searching California Law (<http://leginfo.legislature.ca.gov/faces/codes.xhtml>) which consists of 29 codes covering various subject areas, the State Constitution and Statutes. Excerpts are utilized in this section for quick reference. However it is encouraged that the references be viewed in their entirety for full details.

Welfare and Institutions Code Section 17700

This section addresses placement of children with Special Health Care Needs (SHCNs) with foster parents and biological families who have been trained by health care professionals.

Welfare and Institutions Code Section 17710

This section was added as a means of meeting the unique and medically technical needs of children with SHCN in foster care by caretakers who participate in medical training specific to each child's needs. It defines children with SHCNs, medical conditions requiring specialized in-home health care, individualized health care plan team, and specialized foster care homes.

“Medical conditions requiring specialized in-home health care require dependency upon one or more of the following: internal feeding tube, total parenteral feeding, a cardio respiratory monitor, intravenous therapy, a ventilator, oxygen support, urinary catheterization, renal dialysis, ministrations imposed by tracheostomy, colostomy, ileostomy, or other medical regimens, including injection, and intravenous medication.”

Welfare and Institutions Code Sections 17730-17738

These sections refer specifically to the needs of children with SHCNs entering or are in foster care, such as placement of children with SHCNs, the individualized health care plan, the individualized health care plan team, and training by health care professionals.

Section 17730 states that the department shall develop a program to establish foster care homes for children with SHCN.

Section 17731 states the county shall develop a plan to place children with SHCN in foster care; “prior to the placement of a child with SHCN an individual health care plan, which may be the hospital discharge plan, shall be prepared for the child and, if necessary, in-home health support services shall be arranged. “Foster parents shall be trained by health care professionals pursuant to the discharge plan of the facility releasing the child being placed in, or currently in, foster care. Additional training shall be provided as needed during the placement of the child and to the child’s biological parent or parents when the child is being reunified with his or her family.” “Assistant caregivers, on-call assistants, respite care workers, and other personnel caring for children with special health care needs shall complete training of additional training by a health care professional in accordance with paragraph (3).” “No foster parent who is a health care professional or staff member who is a health care professional shall be required to complete any training or additional training determined by the responsible individualized health care plan team to be unnecessary on the basis of his or her professional qualification and expertise.”

Section 17732 states in part, “A child with special health care needs shall not be placed in a group home unless the child’s placement worker has determined and documented that the

group home has a program that meets the specific needs of the child being placed and there is a commonality of needs with the other children in the group home.”

Section 17733 states in part all documentation prepared by the county concerning documentation of a dependent child as a child with SHCN, shall be made part of the child's case record.

Section 17734 states in part that each county shall report to the department on a regular basis on the conduct and effectiveness of the program provided to children with SHCN,

Section 17735 states that a progress report on the programs provided to children with SHCN shall be included in the child welfare services report.

Section 17736 states that counties, regional centers, foster family agencies shall be permitted to place children SHCN in certified foster family homes, small family homes and group homes.

Section 17737 states that children with SHCN who have adoption as a case plan goal should not be denied from receiving services under this program.

Section 17738 states that the department shall adopt emergency regulations to implement a program for children with SHCN.

Health and Safety Code 1507.25

This code authorizes designated, trained caregivers, including relative caregivers, and foster family home parents, who are not licensed health care providers to administer emergency medical assistance and/or injections for specific reasons to a child in foster care. In regards to placement in foster homes, this Code has the potential to keep sibling groups together, decrease the burden on scarce SHCNs homes and promote a “normal” childhood experience.

Section 504 of the Rehabilitation Act of 1973 and the Individuals with Disabilities *Education Act (IDEA)*

Section 504 provides services to students who have a physical or mental impairment that significantly impairs a major life activity. Examples of qualifying disabilities are asthma, allergies, and diabetes, ADD or ADHD. If the child qualifies, the school district must prepare a plan that outlines special services, accommodations, and modifications that will be implemented to assist the student. Also, the IDEA ensures that all children with disabilities have access to a free appropriate public education that emphasizes special education and related services, including an Individualized Education Program (IEP), designed to meet each student's unique needs. All students that qualify under IDEA also qualify for protections under 504, but there are some students who only qualify for 504. Further information can be found in the [California Foster Education Law Factsheets](#) produced by the California Foster Youth Education Task Force.

Specialized Care Rate (SCR) Program and Special Care Increments and Rates

See [ACIN No. 1-05-10 \(April 6, 2010\)](#) and [Errata ACIN 1-5-10E \(May 12, 2010\)](#)

SCR is a program that allows a county to pay a rate greater than the basic rate, on behalf of children who are placed in family homes and require additional care because of health and/or behavior problems. Each county welfare department is responsible for developing, maintaining and administering their county specific specialized care system. The SCR program is an alternative to more costly group home and Foster Family Agency certified home placements. The program promotes placement of special needs children in the least restrictive, most family-like setting. HCPCFC PHNs may be asked to consult with child welfare staff to help them understand the medical needs of foster children so child welfare staff can determine the appropriate levels of special care increments and rates. Most Counties have developed tools to assess competencies to determine rate levels for children with SHCNs. An example follows from Shasta County.*

Additional Information

1. California Foster Youth Education Task Force - <http://www.cfyef.org>

Specialized Care Rate (SCR) Procedure

GUIDELINES AND PROCEDURES			
Cross Reference: Welfare and Institutions Code 11461(e), 11-400(s) (6-8), 11-401.2	Contact Person: Rod Delfer Laurie Bell	Approved By: Lynne Jones Brad Seiser	Effective Date: January 2007
Supersedes: Policy and Procedure effective date 09/01/2001			
Title: Specialized Rate Care (SCR) Program			

Background

Specialized care is a system that allows a county to pay a rate greater than the family home basic rate, on behalf of children who receive Aid to Families with Dependent Children-Foster Care (AFDC-FC), who are placed in family homes and require additional care and supervision beyond what is normally expected of a child who is a victim of abuse and neglect, because of health and/or behavior problems. These are children, who without this added care, would end up in a group home, hospital or institution.

The Intent of the Program

Specialized care provides a supplemental payment to the family home provider, in addition to the basic home rate, for the cost of supervision (and the cost of providing that supervision) to meet the additional daily care needs of an AFCD-FC child who has a health and/or behavior problem. Placement of children who need specialized care in family homes complies with the intent of State and federal requirements that a child is entitled to placement in a family environment, in close proximity to the parent’s home and consistent with the best interest and special needs of the child.

Q: What is specialized care?

A: Specialized care provides a supplemental payment to the family home provider, in addition to the family home basic rate, for the cost of supervision (and the cost of providing that supervision) to meet the additional daily care needs of an AFDC-FC child who has a health and/or behavior problem. Placement of children who need specialized care in family

homes complies with State and federal requirements that a child is entitled to placement in a family environment, in close proximity to the parent's home, and consistent with the best interest and special needs of the child. California's SCR setting system promotes these concepts.

Q: Can any AFDC-FC child with a health and/or behavior problem receive a specialized care increment?

A: Children who are placed under the authority of a court order, either as a dependent or ward of the Juvenile Court, relinquishment, voluntary placement agreement or guardianship may be eligible to receive a specialized care rate if the county has a specialized care system. Not all counties in California have a specialized care system.

Q: Are there any restrictions on the type of facility in which the child must be placed to receive a SCR?

A: Children placed in a licensed or approved family home, licensed small family home; the certified home of a Foster Family Agency non-treatment program or the home of a relative or nonrelated legal guardian may be eligible to receive a SCR.

Q: Who is Eligible?

A: Children with a health and/or behavior problem and who are placed under the authority of a court order, either as a dependent or ward of the Juvenile Court, relinquishment, voluntary placement agreement or guardianship may be eligible to receive a SCR if the county has a SCR system, as does Shasta County. Currently, 54 counties in California have SCR programs (<http://www.childsworld.ca.gov/PG1649.htm>).

Q: Are there any facility restrictions?

A: Children placed in a licensed or approved family home, licensed small family home; the certified home of a Foster Family Agency non-treatment program or the home of a relative or non-related legal guardian may be eligible to receive a SCR.

Q: Who Sets the Rates?

A: California's county welfare departments are responsible for developing, maintaining, and administering county-specific specialized care systems. The State provides technical

assistance to counties to modify or adopt a system. Currently 54 counties have specialized care systems.

The specialized care increments for each county are posted below. The last specialized care increment rate change occurred in 2008. The specialized care increment does not receive a cost-of-living adjustment. [ACL 13-62](#) shows the current foster care basic rates.

Please contact the local [Child Welfare Agency Representative](#) for questions pertaining to the SCRs.

You may click on desired county for F-rate

Alameda	Humboldt	Mendocino	San Bernardino	Solano
Alpine	Imperial	Merced	San Diego	Sonoma
Amador		Mono	San Francisco	Stanislaus
Butte	Kern	Monterey	San Joaquin	Sutter
Calaveras	Kings	Napa	San Luis Obispo	Tehama
Colusa	Lake	Nevada	San Mateo	Trinity
Contra Costa	Lassen	Orange	Santa Barbara	Tulare
Del Norte	Los Angeles	Placer	Santa Clara	Tuolumne
El Dorado	Madera	Riverside	Santa Cruz	Ventura
Fresno	Marin	Sacramento	Shasta	Yolo
Glenn	Mariposa	San Benito	Siskiyou	Yuba

All SCR approvals are subject to a review in six months. If there is no change and no rate modification, this renewal need not be presented to the committee, but can be processed by submitting an approved application form.

- Whether an Initial Request or Annual Case Renewal, the SW and foster caregiver must consult the SCR matrix (**Attachment A**) found in Shasta/New to determine the proper classification level.
- If the child is placed out-of-state, or in a California county other than Shasta, the SW must obtain that county's matrix, rates and application, and use that information for the application.
- The SW must then prepare a Specialized Rate Care Application (**Attachment B**) also found in Shasta/New. (If the other county does not have an application form, you may use Shasta County's, but must use the other County's rate data.)

- On the SCR Application, indicate whether it is an Initial Placement, Change Request or Annual Renew, or a Six Month renewal with no changes.
- Be as specific as possible on the application. The more information you include on it and in your presentation, the faster the approval process will be. Include information like:
- What is the foster care parent doing to warrant SCR rating?
- Include specific behavior problems that require additional special care from the foster parent.
- Include specific medications and frequency of administering.
- Include specifics about hygiene, bed wetting, physical impairments and their care.
- If you are requesting a Level III or Level IV rate, you must include and present additional documentation:
- Proof that the child has been seeing a counselor, how long and with what frequency.
- A summary of the counselor's progress reports.
- Documented history of violence (describe incidents, when, where, any weapons involved).
- Documentation of medical visits and physician(s)'s prognosis.
- Documentation of special actions that the caregiver has to perform to keep this child viable.
- SCR renewals should stay in the same time frame as Annual Case Renewals, so best practice is to do an additional renewal in a shorter timeframe than 6 months in order to synchronize the renewal schedules.
- Obtain your **supervisor's signature** in the "Recommended by" section.
- Route the signed application to the SCR Placement Clerk. Requests must be received by the Clerk no later than Friday in order to be scheduled during the following week's SCR committee meeting at 2:00 p.m. If you are unavailable for the presentation, please ensure that your supervisor or a co-worker is present.

NOTE: Notice that there are some restrictions on what children are eligible for SCR rates. Keep in mind also that there are other funds available to assist with these children's care.

- Special Care Rates are only available for children receiving the basic home rate. It is not available to FFA homes, group homes or foster homes receiving the Receiving Home Rate, or foster homes receiving a Therapeutic Rate. Those children placed under contract with Far Northern are not eligible for an SCR.

- Children receiving SCR may also be eligible for Special Needs Allocation Funds. Special Needs forms are available in Shasta/New and don't need to go to committee. This form must be approved by a Program Manager prior to routing to the Placement Clerk for processing. (If rates differ, ensure that you complete a separate form for each child. If one rate is to cover all children in the home, indicate that on the form.)

Current Special Needs Allocation Rate		\$58.00	
As of December 2006			
SCR Level I Rate	SCR Level II Rate	SCR Level III Rate	SCR Level IV Rate
\$182	\$360	\$721	\$991

Attachment A to SCR procedure, revised 3/14/07

Specialized Care Rate (SCR) – Foster Care Matrix

Classification	Level I - Moderate	Level II - Intensive	Level III – Extreme	Level IV – Extraordinary
Medically Fragile Child:	HIV positive or other clinically well child requiring close supervision and monitoring under doctors care.	Condition that requires close monitoring, and frequent intervention to keep child stable.	Condition that requires continuous monitoring and/or intervention on a daily basis, i.e. daily injections, tube feeding, breathing treatments, therapeutic exercises, etc.	Requires continuous 24-hour-a-day in-home care and supervision on daily basis in accordance with a professional treatment or behavior management plan that otherwise would require placement in an institution setting.
Respiratory Problems: (Age of child must be considered in setting rate.)	Routine treatments and medications, small doses of oxygen and monitoring.	Frequent breathing difficulties requiring very close supervision of medications, and breathing assistance devices and treatments. Multiple monthly medical appointments.	Extensive breathing difficulties, very close supervision of medications, and breathing assistance devices and treatments. Oxygen and other emergent care as needed 24 hr. Multiple monthly medical appointments	Life-threatening extreme breathing difficulties, very close supervision of medications, and breathing assistance devices and treatments. Oxygen, Pulmonade, suction, tracheotomy, etc. and other emergent care on a daily basis. Multiple medical appointments monthly.
Diabetes: (Age of the child must be considered in setting level.)	Special diet preparation, sugars level monitoring, and close supervision of self-administered medications.	Special diet needed, very close monitoring of food consumption. Close supervision of injection. Monitoring of daily blood sugar testing. Multiple monthly medical visits.	Same as Intensive, but with a resistive child which could be life threatening. Child in addition is in counseling with more frequent medical appointments and/or medically qualified caretaker administering injections.	

1. Foster parents and relatives receiving the Level I rate and beyond are required to be currently enrolled in or have completed basic training requirements as defined by Shasta County’s Licensing Office. In addition, foster parents must continue their education by participating in annual in-service training and maintain current CPR, Infant CPR (when caring for infants) and First Aid Certificates.

2. In addition, to Level I requirements, foster parents and relatives shall be enrolled in or have completed specialized training in the care of medically fragile, behavioral problem, or drug and alcohol exposed children as offered through the Foster Education program at Shasta College.

Classification	Level I - Moderate	Level II - Intensive	Level III – Extreme	Level IV – Extraordinary
Drug Exposed Infants/Children:	HIV positive, clinically well child with mild to moderate symptoms of sleeping, eating, crying disorders, etc.; monitoring required for safety of the child.	Asymptomatic Aids or Fetal Alcohol Syndrome with mild complications, extensive sleep, eating or crying disorders, etc. Medical devices required for maintenance of the child’s well-being, i.e., Apnea monitor, etc., History of seizures, mild and infrequent. Multiple daily needs.	Symptomatic AIDS or Fetal Alcohol Syndrome with moderate complications. Severe drug withdrawal behaviors. Medical device required and multiple medications. Seizers (active) controlled. Extensive medical follow-up which requires multiple visits each month to doctors other than routine visits.	Symptomatic AIDS or Fetal Alcohol Syndrome with severe complications. Life dependent on attachment on medical devices. Severe complications from drug withdrawal. Multiple medications and intravenous treatments. Extensive involvement with various medical providers due to multiple complications. Seizures active and uncontrolled.
Physical Handicaps: (Age of child must be considered in setting level.)	Diagnosed condition or at high risk and requiring close monitoring, moderate supervision, and/or intervention. Child’s condition is stable with few disruptions. Medical follow-up is essential; i.e. thyroid or growth hormone deficiency requiring close therapy & supervision. DD child daily therapy per occupational/physical therapist.	Condition requiring close to almost continuous monitoring and supervision, with frequent intervention. Child’s condition is stable or stabilizing. Enuresis and/or encopresis medically diagnosed 2 or more times a day. May be in a wheelchair but can get around on own and can provide own personal care with little assistance.	Condition requires continuous monitoring and supervision and frequent daily intervention. Child’s condition is frequently unstable. May be in a wheelchair and needs help to get around and with own personal care. Colostomy.	In addition to intensive care, child is unable to provide own personal care may be confined to bed or special chair and require 24-hr. total care. A child as described under intensive but over the age of 12 or weighing 100 or more pounds. Child would require a hospital placement if they left foster home.

Classification	Level I - Moderate	Level II - Intensive	Level III – Extreme	Level IV – Extraordinary
<p>Abnormal Behaviors and Emotional Disturbances:</p> <p>(Age of the child must be considered in setting level.)</p>	<p>Exhibits disruptive behaviors on almost a daily basis that require closer supervision than would be true of the average child placed in foster care. Behaviors are evidenced in the home and at school</p> <p>Often acts before thinking, shifts excessively from one task to another, short attention span. Has difficulty sitting still or fidgets. A pattern of disobedience, negativism, argumentative, and provocative opposition to authority figures. Poor age appropriate social skills, with few long or close friends and no or little evidence of trust, and reliance on others.</p> <p>Enuresis evidenced by repeated involuntary voiding by day or night that is not due to a physical disorder of children six years of age or under.</p> <p>Encopresis evidenced by repeated voluntary or involuntary passage of feces into places not normally considered appropriate. Condition is not</p>	<p>In addition to Level I the child evidences – chronic violations of a variety of important rules (that are important, reasonable and age appropriate for the child) at home or at school. Episodic physical violence and vandalism against property. Episodic running away from home overnight. Persistent serious lying in and out of the home. Stealing or thefts in and out of the home. Impairment in impulse control, poor social judgement and/or sexual acting out. Mood swings, depression, apathy. Feelings of inadequacy and low or inflated self-esteem. Poor school performance with frequent truancy. Social isolation or withdrawal. Inappropriate and intense anger, anger outburst or tantrums; irritability and aggressiveness as evidenced by frequent fights.</p> <p>Enuresis or encopresis involving a child usually age 6 to 11 years of age.</p>	<p>In addition to Level I and II the child evidences - Physical violence against persons. Suspicious or paranoid ideation. Odd or bizarre ideation or magical thinking. Marked impairment in personal hygiene. Behavior that is grossly disorganized. Abuse of alcohol or drugs - beyond experimentation and effecting daily functioning at home and school. Physically self-damaging act, self-mutilations, recurrent accidents, and physical fights. Recurrent thoughts of death, suicidal ideation, wishes to be dead or suicide attempts.</p> <p>Enuresis or encopresis involving a child usually age 12 years of age or older.</p>	

Classification	Level I - Moderate	Level II - Intensive	Level III – Extreme	Level IV – Extraordinary
	due to a physical condition in a child usually 6 years of age and under.			

Classification	Level I - Moderate	Level II - Intensive	Level III - Extreme	Level IV – Extraordinary
<p>Developmental Disabilities:</p> <p>(Child is Far Northern eligible with placement in non-vended home.)</p>	<p>Condition requiring close monitoring, moderate supervision, and intervention. Child's condition stable with very few disruptions. Medical follow-up is essential.</p>	<p>Requiring close to almost continuous monitoring, supervision, and frequent intervention. Child's condition is stable or stabilizing. Enuresis and/or encopresis medically diagnosed 2 or more times a day.</p>	<p>Requiring continuous monitoring and supervision and requiring frequent daily intervention. Child's condition is frequently unstable.</p>	<p>A child who is unable to provide owns personal care. Maybe confined to bed or special chair and require total care. Lifting of child required.</p> <p>A child requiring lifting and as described under Intensive, but over the age of 12 or weighing 100 or more pounds.</p> <p>A child requiring an Institution placement if they left foster care</p>

Initial Application Change Request Annual Renewal

Recommended SCR Level: _____ Child's County of Residence: _____

Child's Name: _____ Age: _____ DOB: _____

Case Name: _____ Foster Parent's Name: _____

Type of Placement: _____

Social Worker's Name: _____ Case Number: _____

Medical Information

Physician: _____ Visits: _____ Week Month Katie A

Diagnosis: _____

Prognosis: _____

Medications: _____

Special Care: _____

Equipment/Monitors: _____

Physical Therapy: _____

Counseling

Counselor: _____ Visits: _____ Week Month

Diagnosis: _____

Prognosis: _____

Medications: _____

Care and Supervision

Behavior: _____

Personal Care: _____

Supervision: _____

Placement Barriers: _____

Approvals

Recommended by (Supervisor) Signature: _____ Date: _____

Specialized Care Rate of _____ County is authorized at _____ level of care for \$ _____ effective _____.

Denied, Reason: _____

Program Manager's Signature: _____ Date authorized: _____

Extended Foster Care (AB 12 and AB 1712)

Definition

The Extended Foster Care (EFC) program began January 1, 2012. This program allows a youth who turns 18 while in foster care to voluntarily remain in foster care provided one of the participation conditions is met, as outlined in [ACL No. 10-69](#). With the passage of SB 1013, a non-minor dependent (NMD) may stay in foster care up to age 21 provided that she/he continues to meet the participation conditions. All foster youth who turn 18 while under the court's order for foster care placement is considered a NMD. There has been confusion as to whether a court hearing or specific finding is required to establish the foster youth as a NMD. Neither a hearing nor additional court findings are required for NMD status or to be considered participating in EFC. See W&IC section 11400(v) for the definition of NMD. The EFC is only an extension of foster care, not a separate foster care program (See [ACIN 1-29-13](#).)

Rights of the NMD Youth in Probation

Hearings can be attended only by those invited by the youth; no protective custody warrants; the court cannot order psychotropic medications; no caregiver consents for medical/education decisions; NMD has privacy rights about medical information; there is no discussion of educational limits on parents, and personal rights of foster children do apply. However, a youth under delinquency jurisdiction will have the full rights once the court has found that he/she has successfully met his/her rehabilitative goals.²

Eligibility

Youth in the juvenile justice system who had an order for foster care placement on their 18th birthday and who turned 18 on or after January 1, 2012; meet at least one of the participation conditions*; agree to meet with the case manager and work on transitional independent living skills; reside in a licensed or approved setting and participate in 6 month

² Two Years of AB 12, Ensuring Probation youth have equal access", Nov. 21, 2013. Webinar presented by The John Burton Foundation.

court review hearings. *Conditions refer to the youth meeting at least one of the following: be enrolled in high school or equivalent program; be enrolled in college/vocational school; work at least 80 hours / month; participate in a program that assists in a job search or unable to do one of the above because of a medical or mental health condition. Also, youth are not eligible for extended foster care while incarcerated because they are at that time not able to reside in a licensed or approved placement.

Roles and Responsibilities

There is a mutual agreement (SOC 162) between the youth and the case manager that specifies the following:

Youth is willing to

- Remain in a “supervised placement”
- Report changes relevant to eligibility and placement
- Work with the Agency on the implementation of the transitional independent living plan (TILP)
- Participate in 6 month review hearings

The Case manager is responsible to

- Help the NMD develop and achieve goals
- Review and update TILP every 6 months
- Help NMD remain eligible for extended care by responding to problems and connecting NMD to supports/services
- Help NMD and caregiver develop Shared Living Agreement
- Ensure NMD has Medi-Cal card or other health insurance
- Provide NMD with contact information for his/her attorney

The PHN is responsible for

- Maintaining his/her role as medical consultant to the case manager regarding any ongoing or new medical diagnosis and appropriate referrals as needed.
- Provide health expertise with reviewing medical records; actively participate as a member of a multi-disciplinary team in planning their individual health care plan.

- Document any of the health information from the CHDP PM 160 in the HEP and follow up any referrals coded 4 or 5 if the youth is in out of home placement.
- Confer with the case manager and others regarding the medical issues of the NMD.
- The PHN activities above occur only if the NMD desires ongoing health care coordination from the PHN and chooses to give written consent for the sharing of their personal health information.

Youth and Probation: this is a youth who has been removed from his or her parent or guardian and ordered to live with a non-parent placement, regardless of federal eligibility; and is in a “suitable placement”. A youth does not need to originate in the foster care system to be an out of placement youth in the juvenile probation system.

Relative to the number of foster youth who are wards of the court, the number in juvenile probation is small; yet their needs are great.

CHDP and Dental Services:

Foster Care youth are eligible for CHDP exams according to the periodicity chart up to the age 21 years. When the youth becomes an adult, he/she is eligible for Denti-Cal if they agree to stay within the foster care system.

Sensitive and Confidential Information

Every child in out of home care will have a HEP which documents and organizes their health and education information. Information contained in the HEP is considered protected health information (PHI) and is to be used or disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Research indicates that adolescents list concerns about confidentiality as the number one reason they might forgo medical care. A young person is more likely to disclose sensitive information if he or she is provided with confidential services and has time alone with the provider.

However, providers including HCPCFC PHNs indicate that they are mystified and confused by the various confidentiality and consent laws as well as their child abuse reporting

responsibilities. HPCFC PHNs often wonder whether or not entering such information as a foster child's family planning, sexual health, mental health information would jeopardize their placements. No confidential information should be put in the HEP without the minor's written consent.

The toolkit, [Understanding Confidentiality and Minor Consent in California, was](#) compiled by a multi-disciplinary group of lawyers, health care providers, SWs, and youth advocates who were striving to clarify these issues. Discussions have also generated numerous questions and general answers as noted in the following pages. Legal advice on specific situations must come from respective County Counsels.

Questions regarding Sensitive and Confidential information for minors and non-minor dependents in Foster Care:

Questions 1-5 reference the chart within the "Adolescent Tool Kit, page 7.

1. Q: Who is legally obligated to obtain the "release of information" from a minor who is a ward of the court?

A: The CSW

NOTE: Refer to your County Policy & Procedure/Practice Guide for more details as this may vary from county to county.

2. Q: Is a verbal authorization for release of information adequate (from the minor to CSW or PHN)?

A: No. Authorization is required in writing.

3. Q: Some counties have "universal release of information forms" and include the entities that would be allowed to share information (i.e. physician, social services, public health, probation) can SCPs be included in this list?

A: No. Combining a Release of Info with consent to care is prohibited as HIPAA and CMIA have different rules and regulations. For example, HIPAA requires several notices of rights versus CMIA that requires a 14-point font!

4. Q: When a Public Health Nurse obtains confidential/sensitive information from a provider or child/youth – where can this information be kept?

A: The answer to this question varies depending on the nature of the information obtained. Legal judgments calls need to be made at local levels.

NOTE: Refer to your County Policy & Procedure/Practice Guide for specific information on how your County keeps Children confidential/sensitive information.

5. Q: Sensitive information for non-minor dependents (12 and older) is not entered in the HEP without their consent. Can sensitive information be entered in the HEP if the child is 8 y/o?

A: Refer to your County Policy & Procedure/Practice Guide for specific information on how your County documents Children confidential/sensitive information in the HEP.

6. Q: What can be done if the NMD has a life threatening condition and refuses services?

A: Both minors and NMDs have the right to refuse services. Refer to your County Policy & Procedure/Practice Guide for specific information.

7. Q: If a young teen 12-18 youth has a pregnancy/STD test and the results are either negative or positive; do we need the minors consent to provide the information to the SW or include that information in the HEP?

A: The PHN feels that to include the information is pertinent to the child's health and to provide appropriate education to the youth.

NOTE: Refer to your County Policy & Procedure/Practice Guide for specific information on how your County documents Children confidential/sensitive information in the HEP.

8. Q: Does the SCP need to know about all of the child's health conditions?

A: There are sensitive health conditions that the SCP doesn't need to know about, but the child's medical provider does need to know. (See your county's sensitive condition information policy for detail.) For this reason we will use *Other Physical Condition* in *Type* and using ICD 9/10 codes in the *Description* area on the *Diagnosed Condition* page. If the SCP needs to know, it will be the SW who gives them the information.

9. Q: Should the HCPCFC PHN spell out mental health diagnoses or use ICD9/10 codes?

A: Rationale for using codes: provides a layer of protection for youth. Rationale for spelling out diagnoses: allows better access of information for caregivers.

NOTE: Refer to your County Policy & Procedure/Practice Guide for specific information on how your County documents Children confidential/sensitive information in the HEP.

10.Q: Is the JV-220 required for NMD's?

A: No. Even though we manage the NMD's HEP, they don't require court's consent for psychotropic medications.

11.Q: Are the PHNs responsible for having the NMD's psych meds documented in the HEP?

A: Yes. Please see the response to the previous question.

12.Q: Is the court entitled to the information that a female NDM is pregnant or can that remain confidential and be kept from court's knowledge?

NOTE: Refer to your County Policy & Procedure/Practice Guide for more details as this may vary from county to county.

13.Scenario: If a youth [in this case she was 16 and bio mother was aware and in agreement] who is in pre-disposition and has not been declared a dependent, tells her Intake SW and her PHN she wants an abortion and can we help facilitate. But she tells them not to disclose to her foster parent, on-going SW, or anyone else, but agrees to inform the Intake SW supervisor.

Questions:

- a. Are we bound to keep this information confidential, or can we inform other supervisors or management?
- b. Does another assigned SW's/management's need to know supersede the youth's right to confidentiality?

A: Refer to your County Policy & Procedure/Practice Guide for more details as this may vary from county to county.

A PHN was actually put in this position, and kept it confidential, but the youth's bio-father found out from the youth's friend and he spoke to the on-going SW who was unaware and management came down hard on the three employees who knew [PHN, Intake SW, and her supervisor]. This is why is so important to be aware of your county Policy & Procedure/Practice Guide.

c. What was the right thing to do in this case?

Be very familiar of your county Policy & Procedure/Practice Guide

14.After reviewing the Minor Consent Laws and Medical Treatment Laws in California, there still remain some gray areas.

The law states:

“A minor’s medical information that is disclosed to a case manager under section 56.103 may not be further disclosed unless the disclosure is for the purpose of coordinating health care services and the disclosure is authorized by law.” (Civil Code, §56.103(d), 56.13.)

NOTE: Refer to your County Policy & Procedure/Practice Guide for more details as this may vary from county to county. Also you may need to consult with your county counsel

Another gray area is sharing information in the Health Education Passport.

The Lantermans-Petris-Short Act (LPS), provides for the confidentiality of mental health information and records.

“If the patient is a minor, disclosure of confidential information may be authorized by the patient’s parent, guardian, guardian ad litem, or conservator. (W&IC § 5328(d).) However, while a parent or a guardian of a minor generally has access to information on the minor patient’s condition and care (W&IC § 5328(d); Health & Safety Code, § 123110), these legal representatives are not entitled to inspect or obtain copies of a minor patient’s medical or mental health records if the minor has a right to consent to

the care or where the health care provider determines that access to the records would have a detrimental effect on the provider's professional relationship with the minor or the minor's physical safety or psychological well-being. (Health & Safety Code, § 123115.)

Further California Law requires the child welfare agency to maintain a health summary for children in Foster Care and to include this summary in court reports. (Welfare. & Inst. Code §§16010(a), 16501.1 (f) (14).

Questions:

- a. Is there anything forbidden to document into the HEP (that ultimately the health providers, foster parents and the court have access to) without a written consent from a minor dependent? (Include Mental Health and Sexual Health).
- b. Can a JV220 diagnosis and prescribed medications be entered into the HEP without the minor's consent?
- c. What information needs to remain confidential?
- d. If a minor's consent is needed, is there an authorization form authored somewhere in use already?
- e. If a dependent minor is pregnant and wishes to keep pregnancy confidential, what is our professional duty?
- f. If a dependent minor seeks STD treatment, mental health treatment and wishes to keep such treatment confidential what is our professional duty?
- g. Refer to your County Policy & Procedure/Practice Guide for specific information on how your County documents Children confidential/sensitive information in the HEP.

15.Q: What is the age of consent for a minor?

A: Note: Refer to your County Policy & Procedure/Practice Guide for specific information on how your County address this issue as it varies from county to county.

16.Q: Can a younger child refuse all immunizations and growth hormone injections that have been recommended by an Endocrinologist? When lab tests, dental appointments and vision exams are recommended for cavities and failed vision exams, can these tests also be refused by the minor? Who is the legal advocate

for this minor? In the same situation, would a NMD have the right to refuse services as well?

A: Note: Refer to your County Policy & Procedure/Practice Guide for specific information on how your County address this issue as it varies from county to county.

17.Q: At what age can a minor refuse treatment, even if it is non-life threatening?

A: Note: Refer to your County Policy & Procedure/Practice Guide for specific information on how your County address this issue as it varies from county to county.

18. Some PHNs have experienced frustration when a SW is asked to obtain a signed consent for the > 18 y/o, or court appointed guardian consent if the 18 y/o is unable to sign or request to obtain a court order to enter medical information or share this information with other medical personnel. The SW has informed the PHN that the consent is not necessary if the teen is still in the foster care system.

Question: Is this correct and what federal or state regulation or law supports this?

Note: Refer to your County Policy & Procedure/Practice Guide for specific information on how your County address this issue as it varies from county to county.

19.Q: How long is Non-Minor Dependent-NMD (\geq 18 y/o) consent to share medical information good for, if there are no time limits noted on the consent?

A: Consent is not needed for STDs, etc., if the child is less than 12 years of age. If the information is on the HEP prior to that age, what obligation do we have regarding the information the day they turn 12?

20. Who ultimately has access to the HEP?

A: When one hears the phrase "Health & Education Passport", it's easy to assume that it's for the use of health and education providers. However, all caregivers (in the case of multiple placements) can have access to the sensitive information one may not want to share with everyone. E.g., a student may talk to her SW about an unwanted pregnancy or her sexual behavior but may not want her teacher to know all that information about her. Therefore, a number of parties may have access to the HEP which makes answering our questions that much more difficult!

NOTE: Refer to your County Policy & Procedure/Practice Guide for specific information on how your County address this issue as it varies from county to county.

When not sure you about an answer regarding Sensitive and Confidential information for minors and non-minor dependents in Foster Care or your policy is not clear please consult with your county counsel.

References

[AB12 Primer](#)

[Abuse Reporting Requirements](#)

[ACIN 1-05-14 Sharing Information with Caregivers](#)

[California's Fostering Connections: Ensuring that the AB12 Bridge Leads to](#)

[California Nursing Practice Act](#)

[California Registered Nurse Scope of Practice](#)

[Success for Transition Age Foster Youth](#)

Children's Advocacy Institute: www.caichildlaw.org

California Youth Connection: www.calyouthconn.org

The Alliance for Children's Rights: www.kids-alliance.org

[The Role of Public Health Nurses](#)

California Fostering Connections: www.cafosteringconnections.org

[Two Years of AB 12: Ensuring Probation Youth Have Equal Access](#)

Los Angeles County Psychotropic Medication Reference:

http://file.lacounty.gov/dmh/cms1_191102.pdf

<http://www.drugs.com>

<http://www.rxlist.com>

Physician's Desk Reference (PDR): <http://www.pdr.net/>

<http://allpsych.com/disorders/dsm.html>

National Institute of Mental Health:

<http://www.nimh.nih.gov>

Mental Health America

<http://mentalhealthamerica.net>

Other Useful Websites

California Department of Mental Health Services Division

<http://www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx>

Food Drug Administration

www.fda.gov/

National Institute on Drug Abuse (NIDA)

<http://www.drugabuse.gov/>

National Council for Behavioral Health

<http://www.thenationalcouncil.org>

Substance Abuse and Mental Health Services Administration (SAMHSA)

<http://www.samhsa.gov>

Centers for Disease Control and Prevention (CDC)

<http://www.cdc.gov>

Katie A settlement Agreement & Class Action Suit

- www.lacdcfs.org/KatieA/index.html
- <http://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx>

Child Welfare Services/Case Management System (CWS/CMS)

<http://www.childsworld.ca.gov/PG1328.htm>

California Rules of Court 2015.640 Psychotropic Medications

http://www.courts.ca.gov/cms/rules/index.cfm?title=five&linkid=rule5_640

California Code of Regulations, Title 9, Div. 1, Chap 11, Subchapter 1, Article 2

http://www.cbhda.org/go/Portals/0/CMHDA%20Files/Public%20Policy/Title%209%20Regulations/Regs_Title9_Div1_Ch11-12-14-15_Title15_Div1_Ch11.pdf

DMH Information Notice No: 08-24 Authorization of Out of Plan Services

<http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice08-24.pdf>

H.R. 2883 (P.L. 112-34) Title I - Child and Family Services Programs

<http://www.gpo.gov/fdsys/pkg/PLAW-112publ34/content-detail.html>

SB 785 Mental Health Services

[http://www.dhcs.ca.gov/services/MH/Pages/Out-of-CountyPlacements\(SB785\).aspx](http://www.dhcs.ca.gov/services/MH/Pages/Out-of-CountyPlacements(SB785).aspx)

Psychotropic Medication Regulations - Welfare and Institutions Codes 369.5

http://ca.regstoday.com/law/wic/ca.regstoday.com/laws/wic/calaw-wic_DIVISION2_PART1_CHAPTER2.aspx#369.5

Appendix

Administrative Resources

Abuse Reporting Requirements www.rn.ca.gov/pdfs/regulations/npr-i-23.pdf

All County Letters, Program Letters and Notices

California Department of Social Services – All County Letters
<http://www.dss.cahwnet.gov/letternotices/PG2856.htm>

CHDP – Program Letters and Notices
<http://www.dhcs.ca.gov/services/chdp/Pages/CHDPPLPIN.aspx>

Basic Informing & Documentation of Informing (PM357)
for Children in Foster Care Program Placement, CHDP Referral - PM 357
<http://www.dhcs.ca.gov/formsandpubs/forms/Pages/CHDPForms.aspx>

California Juvenile Laws and Rules

National Center for Youth Law- Using the law to improve lives of poor children
<http://www.youthlaw.org>

Teen Law- information of California providers of adolescent-health services
<http://www.teenhealthlaw.org>

Welfare and Institutions Codes 739 (A-G) - Medical Care for Probation
<http://codes.lp.findlaw.com/cacode/WIC/1/d2/1/2/18/s739>

Welfare and Institutions Codes 369 – Medical; Surgical, Dental Care Information
<http://codes.lp.findlaw.com/cacode/WIC/1/d2/1/2/10/s369>

Welfare and Institutions Codes 16010 (A-F) – Health and Education Records of Minors
<http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=15001-16000&file=16000-16014>

AB 490- Ensuring Educational Rights of Foster Youth
http://www.youthlaw.org/events/training/ab_490_ensuring_educational_rights_forfoster_youth/

SB 490- Confidentiality Issues

California Department of Social Services Regulations

The Manual of Policies and Procedures (MPP) Division 31 contain the requirements that shall be met by the county in the administration of child welfare services and by the county probation department when the probation department places children in out-of-home care. The following requirements are pertinent to the HCPCFC program:

31-206 Case Plan Documentation

.3 For children receiving out-of-home care, the social worker shall also document in the case plan, the following:

- .36 A plan which will ensure that the child will receive medical and dental care which places attention on preventive health service through the Child Health and Disability Prevention (CHDP) program, or equivalent preventive health services in accordance with the CHDP program's schedule for periodic health assessment.
- .361 Each child in placement shall receive a medical and dental examination, preferably prior to, but not later than, 30 calendar days after placement.
- .362 Arrangements shall be made for necessary treatment.

31-405 Social Worker Responsibilities for Placement

- .1 When arranging for a child's placement the social worker shall:
 - (m) Ensure that information regarding available CHDP services is provided to the out-of-home care provider within 30 days of the date of placement.
 - (n) Ensure that the child receives medical and dental care which places attention on preventive health services through the Child Health and Disability Prevention (CHDP) program, or equivalent preventive health services in accordance with the CHDP program's schedule for periodic health assessment.
- (1) Each child in placement shall receive a medical and dental examination, preferably prior to, but not later than, 30 calendar days after placement.

California's Medicaid State Plan (Title XIX)

The Medicaid State Plan is based on the requirements set forth in Title XIX of the Social Security Act and is a comprehensive written document created by the State of California that describes the nature and scope of its Medicaid (Medi-Cal) program. It serves as a contractual agreement between the State of California and the federal government and must be administered in conformity with specific requirements of Title XIX of the Social Security Act and regulations outlined in Chapter IV of the Code of Federal Regulations. The State Plan contains all information necessary for the Centers for Medicare and Medicaid Services (CMS) to determine if the State can receive Federal Financial Participation (FFP).

[California State Plan](#)

[Approved State Plan Amendments](#)

[Pending State Plan Amendments](#)

<http://www.oal.ca.gov>

CMS Directory

<http://www.dhcs.ca.gov/formsandpubs/publications/Documents/CMS/CMSDirectory.pdf>

CMS Plan and Fiscal Guidelines (PFG)

<http://www.dhcs.ca.gov/formsandpubs/publications/Pages/CMSPFG.aspx>

HCPCFC Performance Measures Reporting Forms

<https://www.dhcs.ca.gov/formsandpubs/publications/Pages/CMSPFPG.aspx>

Federal Laws/Regulations

Social Security Act, Title IV- Grants to states for aid and services to needy families with children and for Child Welfare Services

http://www.ssa.gov/OP_Home/ssact/title04/0400.htm

QA/QI Measures

Business Objects- is a software “gateway” for accessing CHDP reports. Can be accessed by the State and local CHDP program staff

www.dhcs.ca.gov/services/ccs/cmsnet/Pages/BusinessObjects.aspx

Safe Measures- a web based reporting application which provided managers with key performance and outcome measures

Each county is responsible for providing access to this web base reporting system

Berkeley Website- this is a comprehensive data source that allows those working at the county and state level to examine performance measures overtime. The Center for Social Services Research (CSSR) conducts research, policy analysis and program planning, and evaluation directed toward improving the public social services.

http://cssr.berkeley.edu/ucb_childwelfare/

State Laws/Regulations

Welfare and Institutions Code Section 16501

As used in this chapter, “child welfare services” means public social services which are directed toward the accomplishment of any or all of the following purposes: protecting and promoting the welfare of all children, including handicapped, homeless, dependent, or neglected children; preventing or remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation, or delinquency of children; preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family where the prevention of child removal is desirable and possible; restoring to their families children who have been removed, by the provision of services to the child and the families; identifying children to be placed in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate; and ensuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption.

Welfare and Institutions Code Section 16501.3

(a) The State Department of Social Services shall establish a program of public health nursing in the child welfare services program. The purpose of the public health nursing program shall be to identify, respond to, and enhance the physical, mental, dental, and developmental well-being of children in the child welfare system.

(b) Under this program, counties shall use the services of a foster care public health nurse. The foster care public health nurse shall work with the appropriate child welfare

services workers to coordinate health care services and serve as a liaison with health care professionals and other providers of health-related services. This shall include coordination with county mental health plans and local health jurisdictions, as appropriate.

(c) The duties of a foster care public health nurse shall include, but need not be limited to, the following:

(1) Documenting that each child in foster care receives initial and follow-up health screenings that meet reasonable standards of medical practice.

(2) Collecting health information and other relevant data on each foster child as available, receiving all collected information to determine appropriate referral and services, and expediting referrals to providers in the community for early intervention services, specialty services, dental care, MHSs, and other health-related services necessary for the child.

(3) Participating in medical care planning and coordinating for the child. This may include, but is not limited to, assisting case workers in arranging for comprehensive health and mental health assessments, interpreting the results of health assessments or evaluations for the purpose of case planning and coordination, facilitating the acquisition of any necessary court authorizations for procedures or medications, advocating for the health care needs of the child and ensuring the creation of linkage among various providers of care.

(4) Providing follow-up contact to assess the child's progress in meeting treatment goals.

(5) At the request of and under the direction of the non-minor dependent, as described in subdivision (v) of Section 11400, assist the non-minor dependent in accessing health and mental health care, coordinating the delivery of health and mental health care services, advocating for the health and mental health care that meets the needs of the non-minor dependent, and to assist the non-minor dependent to assume responsibility for his or her ongoing health care management.

(d) The services provided by foster care public health nurses under this section shall be limited to those for which reimbursement may be claimed under Title XIX at an enhanced rate for services delivered by skilled professional medical personnel. Notwithstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation, as provided under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), is available.

(e) (1) The State Department of Health Care Services shall seek any necessary federal approvals for child welfare agencies to appropriately claim enhanced federal Title XIX funds for services provided pursuant to this section.

(2) Commencing in the fiscal year immediately following the fiscal year in which the necessary federal approval pursuant to paragraph (1) is secured, county child welfare agencies shall provide health care oversight services pursuant to this section, and may accomplish this through agreements with local public health agencies.

(f) (1) Notwithstanding Section 10101, prior to the 2011–12 fiscal year, there shall be no required county match of the nonfederal cost of this program.

(2) Commencing in the 2011–12 fiscal year, and each fiscal year thereafter, funding and expenditures for programs and activities under this section shall be in accordance with the requirements provided in Sections 30025 and 30026.5 of the Government Code.

(Amended by Stats. 2012, Ch. 846, and Sec. 54. Effective January 1, 2013.)

AB 1111 (chaptered 7/22/99) – added sec. 16501.3 to W and I Code

Debt collection: homeless youth.

Existing law requires the Judicial Council to adopt guidelines for a comprehensive program concerning the collection of moneys owed for fees, fines, forfeitures, penalties, and assessments imposed by court order. This bill would prohibit a court from garnishing wages or levying a bank account for the enforcement and collection of fees, fines, forfeitures, or penalties imposed by a court against a person under 25 years of age who has been issued a citation for truancy, loitering, curfew violations, or illegal lodging that is outstanding or unpaid if the court obtains information that the person is homeless or has no permanent address, as defined. This bill would authorize a court to use these collection procedures when that person is 25 years of age or older, or if the court subsequently obtains evidence that the individual is no longer homeless. The bill would make related findings and declarations.

SB 543 (9/28/99) – amended sec. 16010 and added sec. 369.5 to W and I Code

Children: psychotropic medication: foster care.

Existing law requires that the case plan of a child when he or she is placed in foster care, to the extent available and accessible, include the health and education records of the child, as specified. Existing law requires that at the time a child is placed in foster care the child's health and education records be reviewed and updated and supplied to the foster parent or foster care provider with whom the child is placed.

This bill would revise these provisions by requiring the case plan for each child and specified court reports and assessments to include a health and education summary, as specified, for each child. The bill would require the child protection agency to provide the caretaker with a current summary, as specified. The bill would also require the child's caretaker to maintain information regarding the minor's health and education, and would require the child protection agency or its designee to inquire of the caretaker whether there is any new information to be added to the child's summary. The bill would also require the court, at the initial hearing, to direct each parent to provide the child protective agency complete health and education information, including specified information regarding the child's parents. To the extent that these requirements would increase the duties of local public employees, this bill would impose a state-mandated local program. This bill would also provide that if a child is adjudged a dependent child of the juvenile court and the child is taken from the physical custody of the parent, only a juvenile court judicial officer shall have authority to make orders regarding the administration of psychotropic medications for that child, except that juvenile court may issue a specific order delegating this authority to a parent upon making findings on the record that the parent poses no danger to the child and has the capacity to authorize psychotropic medications. The bill would also authorize a court to permit the administration of psychotropic medication to the child only as specified, and would require the Judicial Council to adopt rules of court and develop appropriate forms for these purposes on or before July 1, 2000. It would also provide, however, that these provisions do not

supersede local court rules regarding a minor's right to participate in mental health decisions. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed \$1,000,000 statewide and other procedures for claims whose statewide costs exceed \$1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

AB 12- California Fostering Connections to Success Act

This bill, which advocates and stakeholders fought for 2 years, includes a number of improvements to the Kin-GAP program and extends foster care to age 21. These changes to the foster care system will also require the development of a number of regulations regarding approval and licensing of foster care placements for non-minor dependents, eligibility requirements for maintaining dependency as a non-minor, changes to the existing Independent Living Program, county share of costs, rate-setting for THP-Plus Foster Care, and a bevy of issues related to the new Kin-GAP model.

AB 1712- Minors and non-minor dependents: out-of-home placement.

Existing law, the California Fostering Connections to Success Act, revises and expands the scope of various programs relating to the provision of cash assistance and other services to and for the benefit of certain foster and adopted children, and other children who have been placed in out-of-home care, including children who receive Aid to Families with Dependent Children-Foster Care (AFDC-FC), Adoption Assistance Program, California Work Opportunity and Responsibility to Kids (Cal Works), and Kinship Guardianship Assistance Payment Program (Kin-GAP) benefits. Among other provisions, the act extends specified foster care benefits to youth up to 19, 20, and 21 years of age, described as non-minor dependents, if specified conditions are met, commencing January 1, 2012. This bill also would make a non-minor dependent who has been receiving specified aid, as described above, between January 1, 2012, and December 31, 2012, and who attains 19 years of age prior to January 1, 2013, eligible to continue to receive that aid, notwithstanding the age limitations in existing law, provided that the non-minor dependent continues to meet all other applicable eligibility requirements. This bill would impose a state-mandated local program by increasing county duties. This bill would extend the date by which the State Department of Social Services is required to develop certain regulations to implement the extension of the above-described benefits to non-minor dependents, from July 1, 2012, to July 1, 2013.

California Ombudsman for Foster Care:

<http://www.fosteryouthhelp.ca.gov/ombprog.html>

Our toll-free number: **1-877-846-1602**

Our e-mail address: fosteryouthhelp@dss.ca.gov

To make a complaint: [Go to our complaints page](#)

Other Ombudsman Offices:

[State Ombudsman offices](#) (as of 11/11)

[Specific County Ombudsman and resource phone numbers](#) (as of 1/09)

DHCS Mental Health Ombudsman for Medi-Cal issues: 1-800-896-4042

The Office of the Foster Care Ombudsman was established by legislation, [California Senate Bill 933 \(Chapter 311/Statutes of 1998\)](#) and has been mandated to do the following:

- Ensure the voice of foster children and youth is heard, and act on their behalf.
- Create an avenue for foster children and youth to file complaints regarding their placement, care and services without fear of retribution from those who provide their care and services.
- Act as an independent forum for the investigation and resolution of complaints made by or on behalf of children placed in foster care and make appropriate referrals.
- Provide children and youth with information on their rights when placed in foster care.
- Maintain a toll-free telephone number which foster children and youth may call from anywhere in California to express their concerns and complaints.

FACTS

- The Foster Care Ombudsman Office established its toll free help line on May 2, 2000.
- The Ombudsman Office is located in Sacramento at 744 P Street.
- The Ombudsman Office compiles all the complaints received and reports them annually to the Legislature.
- The Ombudsman Office hires former foster youth as student assistants.
- An [All County Letter \(ACL #00-58\)](#) was distributed on August 25, 2000 which informs counties that all county SWs are required by SB 933 to provide foster children with information about the Office and the toll-free number.

Regional HCPCFC / Foster Care Nurses

HCPCFC PHNs in other counties are excellent resources regarding health care services. They can also make themselves available to consult with and mentor nurses who are new to HCPCFC.

HCPCFC PHNs meet quarterly (in person or via teleconference) in each of the four regions. For more information contact a nurse in one of the associated counties. County nurse contacts can be found in the CMS Directory.

North:

Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Yolo, Yuba

Bay Area:

Alameda, City of Berkeley, Contra Costa, Marin, Mendocino, Monterey, Napa, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma

Central:

Fresno, Kings, Madera, Mariposa, Merced, San Benito, San Luis Obispo, Stanislaus, Tulare, Tuolumne

South:

Imperial, Inyo, Kern, Los Angeles, Mono, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, Ventura

CHDP county offices:

<http://www.dhcs.ca.gov/services/chdp/pages/countyoffices.aspx>

Conferences:

Annual San Diego International Conference on Child and Family Maltreatment / <http://www.sandiegoconference.org/>

Beyond the Bench Conferences / <http://www.courts.ca.gov/3dca/btb2013.htm>

National Child Advocacy Center / <http://www.nationalcac.org/>

Web Resources and Publications

Health Resources

The American Academy of Pediatrics is dedicated to the health of all children from infancy to young adulthood. Policy statements, publications, clinical practice guidelines, clinical and technical reports regarding pediatrics are available on this website. Specific policy statements on Foster Care include Health Care of Young Children in Foster Care and Health Care for Children and Adolescents in the Juvenile Correctional Care System.

All County Welfare Directors Letters (ACWDLs) and Medi-Cal Eligibility Branch Information Letters (MEBILs) are available on the website for the California Department of Health Care **Services, Medi-Cal Eligibility Branch.**

The California Department of Mental Health has oversight responsibility for public mental health budgets, staff positions and services. It provides a system of leadership for state and local county mental health departments, system oversight, evaluation and monitoring and administration of federal funds. Community MHSs, laws and regulations, publications, county administrators and provider information are available on this website.

The California Mental Health Directors Association (CMHDA) has partnered with Value Options to provide specialty mental health services to children (ages 0-18) placed in out-of-county group, foster home, or kinship placements, and adoption assistance programs. The intent is to better meet the specialty mental health needs for these children, including linguistic and cultural needs, while simplifying the process for practitioners.

Centers for Disease Control and Prevention (CDC) is recognized as the lead federal agency for protecting the health and safety of people - at home and abroad, providing credible information to enhance health decisions, and promoting health through strong partnerships. CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

Legislation

Welfare and Institutions Code, Section 16501.3 (a) through (e).

The State Budget Act of 1999 appropriated State General Funds to the California Department of Social Services (CDSS) for the purpose increasing the use of PHNs in meeting the health care needs of children in foster care. The enabling legislation for the HCPCFC is Assembly Bill 1111.

Policy Letters

All County Information Notice No I-17-95; April 10, 1995

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

All County Letter No 94-105, December 7, 1994

Child Health and Disability Prevention (CHDP) Program Health and Dental Periodicity Schedules

All County Information Notice No. I-55-99, September 2, 1999

New Foster Care Public Health Nurse (PHN) Program in County Welfare Departments

Child Health and Disability Prevention (CHDP) Program Letter No. 99-6, October 21, 1999

Health Care Program for Children in Foster Care

All County Letter No. 99-108, December 2, 1999

Instructions Regarding Local Memorandum of Understanding for Health Care Program for Children in Foster Care

All County Letter No. 00-58, August 25, 2000

California State Ombudsman for Foster Care

All County Welfare Directors Letter No.02-20, April 5, 2002

Continuous Eligibility for Children (CEC) Losing Foster Care

CHDP Program Letter 03-31, December 12, 2003

The CHDP Gateway and Minors in Custody or Detention at the County Level in the Juvenile Justice System

Publications

California Statewide Guidelines for Public Health Nursing in Child Welfare Services (PUB 12) Child Health and Disability Prevention Program, Children's Medical Services Branch, Department of Health Services. May 1999.

Code Blue: Health Services for Children in Foster Care

Institute for Research on Women and Families, Center for California Studies, California State University, Sacramento. March 1998.

Foster Care Fundamentals: An Overview of California's Foster Care System

California Research Bureau, California State Library. December 2001.

Fostering Health: For Children and Adolescents in Foster Care

<http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FosteringHealthBook.pdf>

Now In Our Hands: Caring For California's Abused and Neglected Children

Little Hoover Commission. August 1999.

Still in Our Hands: A Review of Efforts to Reform Foster Care in California

Little Hoover Commission. February 2003.

Understanding the Child Welfare System in California: A Primer for Service Providers and Policymakers,

California Center for Research on Women and Families, Public Health Institute. November 2009. http://www.ccrwf.org/wp-content/uploads/2009/03/final_web_pdf.

Social Services

California Department of Social Services (CDSS) mission "is to serve, aid, and protect needy and vulnerable children and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence." Program-specific websites which may be of use to health care providers serving children in foster care include: Children and Family Services Division, Community Care Licensing Division, Foster Care Ombudsman Program, and Research and Development Division.

Judicial Council of California, Center for Families, Children, and the Courts (CFCC)

is dedicated to improving the quality of justice and services to meet the diverse needs of children, youth, families, and self-represented litigants in the California courts. CFCC resources include case law, rules and forms, publications, self-help, grants, and calendar.

California Department of Developmental Services (DDS) provides services and supports to children and adults with developmental disabilities. These disabilities include mental retardation, cerebral palsy, epilepsy, autism, and related conditions.

University of California Berkeley, Center for Social Science Research, conducts research, policy analysis and program planning, and evaluation directed toward improving the public social services. The Center conducts research and develops reports on foster care for the California Department of Social Services.

Child Welfare League of America is a national, nonprofit organization committed to developing and promoting policies and programs to protect America’s children and strengthen America’s families. Programs, publications, conferences, training sessions and legislative reports are available.

Abbreviations & Acronyms

This section provides commonly used abbreviations and acronyms used by the California Department of Health Services and the California Department of Social Services. (When there have been duplications of abbreviations and acronyms, they may only show in one section.)

California Department of Health Care Services

AAP.....	American Academy of Pediatrics
AB	Assembly Bill
ACIN.....	All County Information Notice
ACL.....	All County Letter
ACWDL.....	All County Welfare Directors Letter
AER.....	Annual Eligibility Review
AFLP.....	Adolescent Family Life Program
BIC	Benefits Identification Card
BY	Budget Year
CalWIN	CalWorks Information Network
CalWORKS.....	California Work Opportunity and Responsibility to Kids
CCR.....	California Code of Regulations
CCS	California Children’s Services
CDC	Centers for Disease Control and Prevention
CDHS	California Department of Health Services
CDSS.....	California Department of Social Services
CFR	Code of Federal Regulations
CHDP.....	Child Health and Disability Prevention Program
CHEAC.....	County Health Executives Association of California
CIN.....	Client Index Number
CLPPP.....	Childhood Lead Poisoning Prevention Program

CMS Net	Children’s Medical Services Network
CMS	Children’s Medical Services; Centers for Medicare and Medicaid Services
CMSP	County Medical Services Program
COHS	County Organized Health Systems
CSHCN	Children with Special Health Care Needs
CTO.....	Compensatory/Certified Time Off
CWS.....	Child Welfare Services
CWS/CMS	Child Welfare System/Case Management System
CY	Calendar Year
DHS 4073.....	CHDP Pre-Enrollment Application
DHS 4505.....	CHDP Report of Distribution
E 47	Enhancement 47
EDC.....	Expected Date of Confinement
EDS	Electronic Data Systems (CDHS’s Fiscal Intermediary)
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EPSDT-SS.....	Early and Periodic Screening, Diagnosis, and Treatment-Supplemental Services
EW	Eligibility Worker
FFP	Federal Financial Participation
FIG	Federal Income Guidelines
FTE	Full Time Equivalent
FY	Fiscal Year
GHPP	Genetically Handicapped Persons Program
GMC	Geographic Managed Care
HCC	Hearing Coordination Center
HCFA.....	Health Care Financing Administration (now known as CMS)
HCPCFC	Health Care Program for Children in Foster Care
HEP	Health Education Passport
HF	Healthy Families
HFP	Healthy Families Program
HIPAA	Health Insurance Portability and Accountability Act
HRIF	High Risk Infant Follow-up Program
HRSA.....	Health Resources and Services Administration
IAA	Interagency Agreement
ICD 10.....	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision
ICD 9.....	International Classification of Diseases, Ninth Revision
IEP.....	Individualized Educational Plan
IFSP.....	Individualized Family Services Plan
IHO	In-Home Operations

IN	Information Notice
LEA.....	Local Education Agency
M & T	Maintenance and Transportation
MC 13	Statement of Citizenship, Alienage, and Immigration Status
MC 210	Statement of Facts (Medi-Cal Only Mail in Application)
MC 219	Important Information for Persons Requesting Medi-Cal
MC 321 HFP	Medi-Cal/Healthy Families Mail-In Application
M/C	Medi-Cal
MCAH.....	Maternal, Child, and Adolescent Health
MCMC	Medi-Cal Managed Care
MEBIL	Medi-Cal Eligibility Branch Information Letter
MEDS	Medi-Cal Eligibility Data System
MMCD.....	Medi-Cal Managed Care Division
MOE.....	Maintenance of Effort
MOU	Memorandum of Understanding
MPP.....	Manual of Policies and Procedures
MRMIB.....	Managed Risk Medical Insurance Board
MTC	Medical Therapy Conference
MTP	Medical Therapy Program
MTU.....	Medical Therapy Unit
NHSP	Newborn Hearing Screening Program
NICU.....	Neonatal Intensive Care Unit
NL	CCS Numbered Letter
Non SPMP	Non Skilled Professional Medical Personnel
NPP	Notice of Privacy Practices
OPRC	Outpatient Rehabilitation Centers
PCFH.....	Primary Care and Family Health Division
PCMS	Program Case Management Section
PFG	Plan and Fiscal Guidelines
PHD.....	Public Health Department
PHN.....	Public Health Nurse
PICU	Pediatric Intensive Care Unit
PIN	CHDP Provider Information Notice
PL.....	CHDP Program Letter
PM 160 INFO ONLY	Confidential Screening/Billing Report (Information Only)
PM 160.....	Confidential Screening/Billing Report (Standard)
PM 161.....	Confidential Referral/Follow Up Report
PM 171 A.....	Report of Health Examination For School Entry
PM 171 B	Waiver of Health Examination for School Entry
PM 272.....	CHDP Annual School Report

PM 357 **CHDP Referral Form**
PO **Probation Officer**
POS **Point of Service Device**
PSA **Program Service Agreement**
PSD **Payment Systems Division**
PSQA **Program Standards and Quality Assurance**
PSS **Program Support Section**
PSU **Provider Services Unit**
RC **Regional Center**
ROS **Regional Operations Section**
SAWS 2 **Statement of Facts for Cash Aid, Food Stamps, and Medi-Cal/State
Run CMSP**
SB **Senate Bill**
SCC **Special Care Center**
SCHIP **State Child Health Insurance Program**
SCRO **CCS Southern California Regional Office**
SELPA **Special Education Local Planning Area**
SFRO **CCS San Francisco Regional Office**
SOW **Scope of Work**
SPC **Substitute Care Provider**
SPHN **Supervising Public Health Nurse**
SPMP **Skilled Professional Medical Personnel**
SRO **CCS Sacramento Regional Office**
SY **School Year**
TCM **Targeted Case Management**
TEMP 602 B **Medical and Dental Exams for Children and Youth and Family Planning
Services, Annual Mail-In Redetermination Referral**
TEMP CA 600 **Annual Review for Cash Aid and Food Stamps**
WIC **Women, Infants, and Children Supplemental Nutrition Program**

California Department of Social Services

AAP **Adoption Assistance Program**
ADD **Attention Deficit Disorder**
ADHD **Attention Deficit Hyperactivity Disorder**
ADS **Alcohol and Drug System**
AFDC **Aid to Families with Dependent Children**
AFDC-FC **Aid to Families with Dependent Children – Foster Care**
AFDC-FG **Aid to Families with Dependent Children – Family Group**
AIDS **Acquired Immuno Deficiency Syndrome**
ARD **Administrative Resource Department**

ASD.....	Administrative Support Division
AST.....	Automated System Technician
BCIS.....	Bureau of Citizenship and Immigration Services
BIA.....	Bureau of Indian Affairs
CAC.....	Children’s Assessment Center
CACI.....	Child Abuse Central Index
CAD IQ.....	Child Abuse Database Interactive Queries
CAF.....	Case Assessment Forum
CAHL.....	Child Abuse Hot Line
CAL CAP.....	California Confidential Address Program
CAPIT.....	Child Abuse Prevention, Intervention and Treatment
CAS.....	County Adoption Service
CASA.....	Court Appointed Special Advocate
CATS.....	Child and Adolescent Treatment Services
CC.....	County Counsel
CC-1.....	Correction Counselor One
CDC.....	California Department of Corrections
CDC.....	Child Day Care
CDRT.....	Child Death Review Team
CDS.....	Child Development Services
CII.....	Criminal Identification and Information
CLETS.....	California Law Enforcement Telecommunications System
COLA.....	Cost of Living Adjustment
CORI.....	Criminal Offender Record Information
CP.....	Case Plan
CPA.....	Child Protective Agency
CPR.....	Concurrent Planning Review
CPS.....	Child Protective Services
CWDA.....	County Welfare Director’s Association
CWEA.....	Child Welfare Improvement Activities
CWLA.....	Child Welfare League of America
CWS.....	Child Welfare Services
CWS/CMS.....	Child Welfare Services/Case Management System
DA.....	District Attorney
DAAS.....	Department of Aging and Adult Services
DAP.....	Description, Assessment Plan
DARE.....	Daily Assessment Review Evaluation
DBH.....	Department of Behavioral Health
DD.....	Deputy Director
DD.....	Development Disability

DEC.....	Drug Endangered Child
DOB	Date of Birth
DOJ	Department of Justice
DPH.....	Department of Public Health
DPSS	Department of Public Social Services
DSM-IV-R	Diagnostic and Statistical Manual of Mental Disorders
DV	Domestic Violence
EA	Emergency Assistance
EA-CRS	Emergency Assistance Crisis Resolution Services
ER	Emergency Response
EW	Eligibility Worker
EWCA.....	Eligibility Worker Case Aide
EVO	Evaluated Out
EYH	Enriched Youth Home
F & O's	Findings and Orders
F2F	Family to Family
FBG.....	Federal Block Grant
FC.....	Foster Care
FCEW	Foster Care Eligibility Worker
FFA	Foster Family Agency
FFACH.....	Foster Family Agency Certified Home
FFH	Foster Family Home
FGDM.....	Family Group Decision Making
FH	Foster Home
FIO	For Information Only
FM.....	Family Maintenance
FP	Foster Parent
FPC(s)	Family Preservation Council
FR.....	Family Reunification
FTT	Failure to Thrive
FYI	For Your Information
FYS	Foster Youth Services
GAL	Guardian Ad Litem
GH.....	Group Home
HEP.....	Health and Education Passport
HIV	Human Immunodeficiency Virus
HOPE	Helping Others Parent Effectively
HRS.....	Human Resource Services
HSS	Human Services System
HV.....	Home Visit

ICP	Inter-County Placement
ICPC.....	Interstate Compact on the Placement of Children
ICT	Inter-County Transfer
ICWA.....	Indian Child Welfare Act
IEP.....	Individual Education Plan
IIN	Interim Instruction Notice
ILP.....	Independent Living Program
ILSP	Independent Living Skills Program
IM.....	Income Maintenance
INS	Immigration and Naturalization Service
IPC	Interagency Placement Committee
IR.....	Immediate Response
ISP.....	Infant Supplemental Payment
ITSD.....	Information Technology Services Department
IQSAB.....	Improving Quality Systemwide Advisory Board
J/D.....	Jurisdiction/Disposition Hearing
JNET	Juvenile Network (Juvenile Dependency Court Information)
JWIS.....	Juvenile Warehouse of Integrated Systems
KG.....	KinGap
KIN-GAP	Kinship Guardian Assistance Program
LE.....	Law Enforcement
LTFC.....	Long Term Foster Care
MDT(s)	Multidisciplinary Team(s)
MEPA	Multi-ethnic Placement Act
MGM.....	Maternal Grandmother
NCIC	National Crime Information Center
NOA.....	Notice of Action
NREFM.....	Non-Related Extended Family Member
N/S	No Show
O & I.....	Orientation and Induction
OA.....	Office Assistant
OHC	Out of Home Care
OOHA	Out of Home Abuse
OOHI.....	Out of Home Abuse Investigation
OES.....	Office of Emergency Services Medical report of Suspected Child Physical Abuse and Neglect Examination
PC.....	Penal Code or Protective Custody as in “Protective Custody Hold”
PCWTA.....	Public Child Welfare Training Academy
PD	Police Department
PDD.....	Program Development Division

PERC.....	Performance, Education and Resource Center
PET	Parent Effectiveness Training
PGM.....	Paternal Grandmother
PHN.....	Public Health Nurse
PID	Program Integrity Division
PMCD	Psychotropic Medication Court Desk
POB.....	Place of Birth
PP	Permanency Planning
PPH	Permanency Planning Hearing
PPLA.....	Planned Permanent Living Arrangement
PRIDE.....	Parent Resources for Information and Education
PPR	Permanency Planning Review
PRC.....	Placement Review Committee
PRUCOL.....	Permanent Residence Under the Cover of the Law
PSC	Pretrial Settlement Conference
PSSF.....	Promoting Safe and Stable Families
PTSD.....	Post Traumatic Stress Disorder
RAJ	Run Away Juvenile
RAU	Relative Approval Unit
RFPC.....	Regional Family Preservation Council
SANS	Subsequent Arrest Notification Service
SAR.....	Semi-annual Review
SARB	School Attendance Review Board
SAWS	Statewide Automated Welfare System
SC.....	Shelter Care
SCP	Substitute Care Provider
SED.....	Seriously Emotional Disturbed
SHCM	Special Health Care Needs
SIDS	Sudden Infant Death Syndrome
SIJS	Special Immigrant Juvenile Status
SIS.....	Special Immigrant Status
SSA	Social Service Aide
SSI.....	Social Security Income
SO	Sheriff's Office
SOG.....	Services Only Guardianship
SSP	State Supplemental Payment
SW.....	Social Worker
TANF	Temporary Aid to Needy Families
TC	Telephone Call
TDM.....	Team Decision Making

THP	Transitional Housing Program
THPP	Transitional Housing Placement Program
TILP	Transitional Independent Living Plan
TPR	Termination of Parental Rights
TRO.....	Temporary Restraining Order
U/S	Undersigned
USC.....	United States Code
USIS	United States Immigration Service
VFM.....	Voluntary Family Maintenance
VFR.....	Voluntary Family Reunification
VW	Victim Witness
W&I	Welfare and Institutions Code
WNL	Within Normal Limits
WPE	Work Performance Evaluation
WSIS	Whiplash Shaken Infant Syndrome
YJC	Youth Justice Center

Definitions (Related to Social Services)

Bates Bill Child.....	Child with Specialized Medical Needs
Deprivation	Determination of Deprivation Worksheet DPSS/FC 2.5
Medi-Cal	California's State Medicaid Program
Miller vs. Youakim	Court order whereby eligibility is determined for foster care
PPR	Permanency Planning Review to determine long term permanent plan for children unable to return home
SAWS	Application for case aid, food stamps and/or medical assistance/SAWS 1
Ten Day.....	Report of abuse assessed to require investigation within ten (10) days
TT.....	Reports of abuse determined to require a prioritized investigation <u>sooner</u> than ten (10) days or within three (3) days
.21e.....	Six (6) month court review for reunification cases
.21f	Twelve (12) month court review for reunification cases
0.22.....	Eighteen (18) month court review for reunification cases
0.26.....	Hearing to implement the recommended Permanent Plan of Adoption, Guardianship or Long Term Foster Care
342.....	Petition to report <u>new facts</u> to the court
387.....	Supplemental petition: Previous disposition has not been effective in the Rehabilitation or protection of the child. Child needs higher level of care.
388.....	Petition (usually initiated by parent) stating the circumstances have changed or there is new evidence asking court to modify the order because of best interest of the child
SAR.....	Semi-annual review (6 month hearing for children placed in their own home)

