

HEALTH/MEDICAL CARE

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V. HEALTH/MEDICAL CARE

Although removal of a child from his/her family is stressful to all, the worker must make a concerted effort to obtain health and other information from the child's family to assist in planning for the child and in the child's adjustment. The worker must record in the case narrative that the health information was given to the provider at the time of initial placement and to any new provider if a child is moved. If the information is not given to the provider, the worker must document the reason.

A. Initial Medical Care/Examination

When a decision is reached that out-of-home care is necessary, arrangements are to be made for a medical examination before a child is placed in foster care. The purpose of the initial medical examination is:

- Record a brief medical history;
- Document the child's medical condition upon entry into care, including visible injuries;
- Determine whether the child is free from contagious disease; and
- Identify needed medical concerns and care needed.

1. Medical Exam

It is preferable that a medical examination be made prior to the child's entry into care. If this is not possible, the examination must be made within 10 days after placement. The initial examination may be obtained through EPSDT (Early and Periodic Screening, Diagnosis, and Treatment Services also known as the MediKids Program) Medicaid Screening if the child is eligible for Medicaid or by a physician or pediatrician. The Medicaid Screening form, the PSD-BFC-623 (Child's Medical Record), or another form providing the same information as indicated on the PSD-BFC-623 should be used.

2. Medicaid Eligibility Determinations

Title XIX, Section 403C, of the Social Security Act requires that all recipients of Medicaid who are under 21 years of age be made aware of the services available under EPSDT. Medical services including medical, dental and vision examinations, physical and occupational therapy, speech therapy, rehabilitation services and psychological services are covered by Medicaid when identified via EPSDT periodic screening or inter-periodic screening and treatment determined to be medically necessary.

Note: Inter-periodic screening (in between regularly scheduled screenings) must be provided when a medical condition is suspected or a condition has worsened or changed sufficiently enough that further examination is medically necessary. The failure to request an inter-periodic screening for children who are hospitalized or who require other medical services can result in the lack of payment by Medicaid. An inter-periodic screening may be performed based on a request by the patient or guardian or based on the provider's professional judgment relative to medical necessity.

When a child is placed in foster care and is eligible for Medicaid, screening should be requested except when a child has already been screened; has had a medical assessment within 3 months prior to placement in foster care; or when a medical assessment other than Medicaid Screening is needed.

To refer a child for Medicaid screening, enter the appropriate information on FACTS for transmittal to Alabama Medicaid Agency. (Client Medical History – EPSDT Information Tab)

County Departments can access information regarding EPSDT providers in their county through computer terminal after signing on to DHR-CICS. Enter MSEPI, followed by the two digit county code (Example: MSEPI, 01). To inquire about out-of-state providers, enter MSEPI, 99 and press the enter key.

Payment for initial examinations made by licensed physicians may be paid for foster children from state funds if not available without cost to the Department. Such service would be considered “available without cost to the Department” when the examination is provided free of charge in a city/county clinic, or by a physician, or when the child receives Medicaid Screening.

When the Department is to make payment for such examinations, the County department is to notify the licensed physician providing the examination that payment may be authorized up to but not exceeding the Medicaid rate, and that on the original copy of his bill, he or his authorized representative must sign and certify that the charges for the examination do not exceed the Medicaid rate.

3. Medical Insurance for Children Who Are Ineligible for Foster Care Medicaid

Some children in out-of-home care will be ineligible for Alabama Medicaid through the two foster care Medicaid categories (IV-E or ACFC). In such situation, child welfare workers shall apply for other medical insurance coverage through Alabama Medicaid and ALL Kids Programs. Applications are located on the Department of Public Health’s website (www.adph.org/allkids) and should be completed and submitted. Completed applications are routed to the ALL Kids program for screening and if the child appears to be SOBRA Medicaid eligible the application is routed to Alabama Medicaid. If the child is not Medicaid eligible, the application will be considered for the ALL Kids program.

Some children may have private insurance known as third party insurance. If this is the case the child’s family insurance should be used as the method of payment. Alabama Medicaid Agency (AMA) requires that the third party insurance be used as the primary insurance before AMA will pay. The worker should explore with the family whether private insurance exist and promptly obtain a copy of the insurance card.

Medical insurance may be purchased from local funds or a child’s private earmarked funds when the child is ineligible for Medicaid. If a child has an accumulation of private earmarked funds or monthly income in excess of the board payment, consideration should be given to purchasing medical insurance with this money. The County Department may purchase insurance from any company willing to provide coverage.

B. Ongoing Medical Care

1. Routine and Periodic Medical Exams

As much prenatal information as possible, including hospital, doctor's report, and postnatal records, should be secured on infants coming into care. For children beyond infancy coming into care, as complete medical history as possible, including the immunization record, should be obtained. This information will be helpful to the doctor who will be caring for the child, and to the agency in relation to planning. Foster care providers should also know what medical care the child has received prior to placement. Unless otherwise recommended by the pediatrician, the following guidelines are recommended in determining the frequency of medical examinations for foster children:

<u>1 mo. To 1 year</u>	<u>1 year to 2 years</u>	<u>2 years through 18 years</u>
at 1 mo.	at 18 mos.	at age 2 years and
at 2 mos.		annually thereafter
at 4 mos.		
at 6 mos.		
at 9 mos.		
at 12 mos.		

FACTS will provide a tickler annually for the physical exam only through the 18th birthday. After the child becomes 18, the physical exam may be given every other year.

2. Authorization for Surgery or Other Medical Treatment, Emergency or Non-Emergency

Parents of children in the temporary custody of the department placed in out of home care must give consent for all surgical procedures and other procedures requiring general anesthesia. In the event parent's whereabouts are unknown, the County Department should obtain assistance of the parent's court appointed attorney and the Guardian-ad-litem to locate parents. If the parents are unable to be located, the County should seek a court order authorizing consent by the County Department. If the parent(s) refuse to consent to a medically necessary procedure, the County Department should contact the Guardian-ad-litem for assistance in obtaining a court order authorizing consent for the procedure. The County Department also may seek a court order authorizing consent when the parent refuses to provide consent. For those children in the permanent custody of the Department, the County Department has authority to give consent. SDHR should be notified of the surgery. (Refer to *Adoption Policies and Procedures* Section DHR Placements for direction of children in permanent custody of the Department)

Institutions usually request that an agreement for emergency surgery or other medical treatment for the child be completed prior to admission to the institution.

3. Experimental Medical Care

Before responding to requests for consent for experimental medical treatment for children (children with HIV infection, AIDS, etc.) in the Department's temporary legal custody, the County Department is to consult with their SDHR consultant for advice and direction. The consultant will, in turn, discuss the issue with the State Legal Office. The request for experimental medical treatment must be discussed with the parents and be included in the ISP and referred by the County Department to the Juvenile Court with a request to either grant or deny permission for the child to participate in the treatment. Parents should be advised of the proposed treatment and given an opportunity to express their reservations or desires in conjunction with the order of the court. Documentation needed by the court before a decision about consent for treatment can be made includes but is not limited to the following: (a) the child's diagnosis and prognosis, both with and without the treatment; (b) potential side effects of the treatment; (c) other treatment options available and pros and cons as to the effectiveness, side effects, effect on quality of life, etc.; (d) consequences to the child if the child is not enrolled in treatment; (e) duration of study and identification of positive effects sought for the child from the study; (f) provisions for confidentiality and intended use and distribution of study data; and (g) explanation given to parents and their reactions or position on including their child in the study.

4. Medications

Children in the care of the Department have varying health needs. Those individuals providing daily care for these children must take precautions in administering medications to children in their care. While every child has individual health needs, there are consistent measures that shall be taken in administering medication to children in the care of the Department. The following should be discussed with all out-of-home care providers.

a. Over the Counter Medications

Out-of-home providers shall follow the procedures listed below when administering over-the-counter medications.

- Carefully read the manufacturer's product information before administering any over the counter medication.
- Underscore the importance of paying close attention to product labels, particularly precautions and contraindications.
- Administer over-the-counter medication to a child **only** if the product information indicates the medication is safe for the age child it is being administered to.
- Administer medications according to the manufacturers' recommended dosage and in the manner prescribed by the manufacturer (e. g. by teaspoon, entire pill, capsule) unless the child's doctor has given written instructions that vary from this.

- When preparing to administer over-the-counter medication, reread the labels to assure that the medication is safe for the age of the child.
- Check the expiration date on the medication container. Out-of-date medication shall not be administered.
- Certain medical conditions contraindicate the use of over-the-counter medications. In these situations, the foster parent and the child's worker shall consult with the child's doctor before administering any over the counter medications.

b. Prescription Medications

Out-of-home providers shall follow the procedures listed below when administering prescription medications:

- Because individuals react differently to medications, give prescription medication **only** to the child for whom it is prescribed.
- Some pharmacies will add a discard date to prescription labels, although this is not required. Any "left over" prescription medication should be discarded.
- Give the medication as directed by the child's doctor.
- If the child appears to have an adverse reaction to the medication, notify the doctor who prescribed the medication for the child. The foster parent also needs to notify the child's DHR social worker about the reaction, and especially if the child is allergic to the medication.
- Keep a log of all prescription medications administered to a child as required in the Minimum Standards For Foster Family Homes.

As stated in the Minimum Standards For Foster Family Homes, Revised 2002,

"All medications shall be secured in a locked storage area that is inaccessible to small children."

In the event of an accidental overdose or adverse reaction to either an over-the-counter medication or a prescribed medication, the Poison Control Center, toll free telephone number 1-800-222-1222, should be contacted.

County child welfare staff shall encourage their foster parents to utilize this information. Foster Parents Associations may also want to bring in medical professionals to train on safe medication administration during association meetings. Such training may be used to meet the training requirements specified in the Minimum Standards For Foster Family Homes.

5. Dental Care

All Medicaid eligible children are to have a dental examination under Medicaid Screening (Early Periodic Screening & Diagnostic Treatment). Annual dental examinations are recommended. These should begin no later than three years of age. Children who do not qualify for Medicaid will have a dental examination authorized through the ISP with payment through local flex funds after other resources have been explored and exhausted.

a. Braces

If the dental examination indicates a medical necessity for braces and or other orthodontic care, local funds may be used for this. Medicaid does not pay for braces except in rare and unusual circumstances. Medicaid requirements state that braces must be a medical necessity and documentation from a health care provider must show evidence of the medical necessity. The caseworker must obtain approval from Medicaid. If the child has third party insurance explore whether this insurance covers braces. The ISP team must determine this is a needed service before payment can be pursued. If a child age fourteen or older is in need of braces and the need can relate to one or more of the Chaffee outcomes and the ISP states a need for braces the worker can explore ILP funds paying for the braces. Contact your state ILP consultant for guidance when these services are being considered for children receiving ILP services.

6. Authorization for Foster Parents and Related Caregivers to Apply for Women, Infants and Children (WIC) Benefits

Approved foster parents and related caregivers of children in the temporary or permanent custody of the Department are authorized to complete and sign certification forms for the WIC Program.

Approved foster parents and related caregivers will be provided with a letter from the County Department verifying that the foster parent or relative has physical custody of the child and DHR has legal custody. A related caregiver is any relative who has the physical care and/or custody of a child, while the Department retains legal custody.

The DHR social worker is not required to complete and sign the authorization for services and income assessment for WIC benefits. If the foster parents or related caregivers are unable to complete the application the DHR worker may complete the certification forms. The DHR social worker should be designated as a WIC proxy when the foster parent/related caregiver completes the certification forms. The foster parent or related caregiver is not authorized to sign for other Public Health Department services.

7. Alabama Medicaid Agency's Prior Authorization Program and Preferred Drug List

The Alabama Legislature passed legislation placing restrictions on medications purchased for Medicaid recipients. The Alabama Medicaid Agency (AMA) implemented a mandatory Preferred Drug List (PDL) and a Prior Authorization Program for any medication not listed on the PDL.

As a result of AMA's PDL, certain drugs will require prior authorization. The PDL and Prior Authorization Program affects the purchase of medications prescribed for some of the drugs children diagnosed with ADHD, ADD and other emotional/behavioral conditions require. Brand preferred drugs, generics and over-the-counter drugs continue to be available without prior approval. Preferred drugs listed on the PDL include covered over-the-counter drugs, generic, and some brand name drugs. Preferred drugs are those medications that have been assessed as safe, efficient, and clinically effective. Some of the medications listed in the PDL include Dexedrine, Dexedrine Spansule, Focalin, Lexapro, Metadate CD, Metadate ER, Paxil, Paxil CR, Ritalin, Ritalin SR, Wellbutrin, Wellbutrin XL, and Wellbutrin SR. AMA will add other medications as they are reviewed and approved. Anti-psychotic and HIV/AIDS drugs are exempt from the preferred drug program and available without prior authorization.

Alabama Medicaid covers some medications not listed on the PDL. However, if a non-preferred medication (i. e. not on the PDL) is ordered, the prescribing practitioner needs to obtain prior authorization in order for Medicaid to pay for the non-preferred medication. The physician will need to document the reason the drug is required, and provide medical justification to support the physician's choice of the requested course of treatment. The prescribing physician is required to provide evidence that at least two (2) prescriptions (generic, over-the-counter or brand name drugs) have been used unsuccessfully within the last six (6) months prior to requesting the prior authorization. If a child has been stabilized on a medication for sixty (60) days or longer the physician must note this on the form when requesting approval in order for the child to remain on the medication. Documentation must show the generic, over-the-counter, or other brand drugs were tried for at least thirty (30) days unless there was an allergic reaction. **Child welfare staff should consult with children's physicians to assure that prior authorization requests are submitted to AMA for medications that are nonpreferred.**

AMA provides the complete PDL on its website, www.Medicaid.state.al.us. To access the list, click on Providers, then PDL under the Pharmacy Program. Since the listing will change periodically, child welfare staff should access the PDL to determine if a child's medication is available without prior authorization.

8. Alabama Medicaid Coverage for Out of State Services

Children in out-of-home care may travel out of state with their provider, their social worker or in certain situations, may travel alone. When a child in out-of-home care travels out of state, child welfare staff shall provide the child and/or provider with a letter on county department letterhead stating that the child is eligible for Alabama Medicaid. The letter must provide the child's name, date of birth, Medicaid number, and the name of child welfare worker. The letter must also include "in the

event Alabama Medicaid is not accepted by out of state provider, SDHR is responsible for paying at the Alabama Medicaid rate.” Counties may obtain a printout of a child’s current Medicaid eligibility through MSIQ. Child welfare staff or Data Entry personnel may request assistance from Family Assistance staff with clearance into a 3270 session.

Services that Alabama Medicaid covers in Alabama may also be covered out of state if:

- There is a certified emergency;
- It would be hazardous or injurious to have the child travel back to Alabama for treatment;
- The medical services needed are more readily available in the other state; or
- An out of state medical provider has a contract with Alabama.

NOTE: The medical provider of services must agree to enroll as a provider with the Alabama Medicaid Agency. Some services must be approved before the service can be given an out-of-state provider number.

C. Children with Specialized Health Care Needs

Foster children living in traditional foster family homes and meeting the criteria as outlined in this section will be eligible for difficulty of care payment or medically fragile payment.

The case record must show that foster parents have completed additional training either as a foster parent, parent, or in some other capacity, care to a child who has been considered to be physically disable, emotionally disturbed, having mental retardation, or with pronounced behavior problems.

Examples of the ways in which foster parents may have provided specialized care may include:

- provision of nursing care for children who are physically or mentally disabled;
- accompanying children to specialized clinics, special education facilities and carrying out physicians’ and clinics’ instructions;
- providing in-home therapy;
- attending scheduled sessions with teachers, doctors, mental health staff, and social workers; and
- reading and carrying out recommended procedures made by the caseworker or other professionals, etc.

1. Difficulty-of-Care Payment

The difficulty-of-care payment to foster parents providing specialized foster home care is \$50 per month per child for a full month’s care. Payment for a partial month should be prorated. Foster parents who receive difficulty-of-care payments are required to have specialized foster care training.

The difficulty-of-care payment is not considered for Federal Income Tax purposes for children under the age of 19.

A child's private earmarked funds should never be used to pay the difficulty-of-care payment. Difficulty-of-care payments are generated through FACTS if documented in FACTS as an add-on to the placement.

a. Criteria for Determining Child's Need for Specialized Foster Home Care

Children should be in the custody of the Department this includes voluntary placement agreements or under the supervision of the Department and in addition must meet one or more of the following:

- Children with a physical disability

A child will be considered to have a physical disability when there is a statement in the case record by a licensed practicing physician which includes a diagnosis of the handicap and specifies instructions for special care. Examples of physical disability which may be considered as warranting special care are: diabetes; visual and hearing defects; muscular or bone condition requiring the use of braces, etc.

- Children who are emotionally disturbed

The child has been diagnosed by a psychologist, psychiatrist, or mental health center as emotionally disturbed. Documentation of such diagnosis must be in the case record.

- Children who have mental retardation

The child must be diagnosed as having mental retardation by a physician, psychiatrist, psychologist, or mental health center. Documentation of such diagnosis must be in the case record.

- Children with pronounced behavior problems

The child is considered by the caseworker, supervisor, director, foster care consultant, or service specialist to have behavior problems which require difficulty-of-care payments. Documentation of the symptoms of such behavior and the worker's identification of the problems with the concurrence of another qualified professional, must be in the case record.

The additional qualified opinion may come from the supervisor, director, of foster care consultant, service specialist, physician, psychiatrist, psychologist, or mental health center. A copy of the complaint and/or petition

alleging “A Child in Need of Supervision” or “Delinquent” may also suffice as such documentation.

Examples of behavior which may be considered pronounced behavior problems are: destructiveness, stealing, or physical aggression.

2. Medically Fragile

Children with special health care needs have chronic physical, developmental, behavioral, or emotional conditions. These children also require health-related services beyond those typically required by other children. Medically fragile children have a condition diagnosed or recognized by a physician that can be volatile and change suddenly resulting in a life-threatening situation. Many of the qualifying children are either HIV positive children, children with developmental disabilities, children with complications associated with premature birth, drug exposed infants or other children who have medically complicated conditions. Foster care providers for medically fragile children must provide a specialized service based on the child’s individualized needs that are beyond “ordinary parental duties.” A difficulty of care rate has been established to reflect the services being rendered by foster parents for those children identified as medically fragile.

Child welfare staff shall observe best practice with regard to health care services for children in care. This includes, but is not limited to:

- determining the child’s medical status and need for medically fragile care at the initial ISP meeting;
- conducting regular monthly face-to-face contact with medically fragile children;
- conducting quarterly, or more often, if needed, communication /contacts with the children’s health care provider (s); and,
- conducting timely ISP meetings (in accordance with ISP policy) to monitor, and review child’s medical and other individualized needs in order to determine whether the child continues to meet the requirements for medically fragile care.

Child welfare staff must recognize and understand that DHR is the “parent” for children in our custody. Therefore, child welfare workers must ensure that children’s health needs are being met and that all medical appointments are kept.

a. Children Who May Qualify For Medically Fragile

The following information is provided to help identify children with conditions that can make them medically fragile. The criteria stress the importance of considering the amount of care required by these children rather than their diagnosis. Even though a child may have a serious or tragic condition such as blindness or deafness, the child may not require care at a level to be considered medically fragile.

Children with any of the following medical conditions can be considered medically fragile. **It is the care requirements of the child rather than the condition/diagnosis that determines if the child is medically fragile.** This is not an all-inclusive listing.

i. Human Immunodeficiency Virus

Human Immunodeficiency virus (HIV) is the virus that causes AIDS. HIV is not easily transmitted or spread through the air, water, by insects, or during ordinary social contact. It has never been transmitted by casual contact. The most common ways that HIV is transmitted from one person to another are by having sexual intercourse (i.e., anal, vaginal, or oral sex) with an HIV-infected person, sharing needles or injection equipment, blood transfusions, or HIV-infected mothers to babies before or during birth, or through breast feeding after birth.

Children who test positive for the Human Immunodeficiency virus (HIV+) are either asymptomatic or symptomatic. It is not uncommon for an infant born to an HIV positive mother to test positive in infancy (0-12) due to the mother's antibodies. Infants testing positive at birth may not be infected by the HIV virus and remain asymptomatic. The infant testing positive at birth for HIV, but is asymptomatic, must have other special care needs to qualify for medically fragile care.

Children who test positive for HIV at birth must be tested every six months until they are two years of age. Children who receive medically fragile care **due to HIV symptoms only** will no longer qualify for medically fragile care if they have tested and received **three consecutive negative HIV tests**, usually completed by two years of age. However, if an HIV positive child has received three negative HIV tests, and receives medically fragile care due to other special care needs unrelated to HIV, a determination must be made, in accordance with ISP policy, of whether medically fragile care will need to be continued.

ii. Drug Exposed Infants

Drug exposed infants (0-12 months) that require specialized caregiving are considered medically fragile. Any or all of the following may be complications/symptoms of drug exposure in an infant when they exhibit at least two of the following seven conditions (All symptoms may not appear in every child):

- Prematurity (childbirth occurs at 32 weeks or less).
- Low birth weight (5 lbs.- 8 oz. or less).
- Low Apgar score (6 or less).
- Small for gestational age.
- Need for ventilator at birth.

- Subacute withdrawal.
- Infections to include congenital viral or bacterial (hepatitis, syphilis, gonorrhea, cytomegalovirus, and HIV).

Behavioral symptoms of drug exposed infants include difficult to comfort, high-pitched persistent cry, hyperactive, and irritability. Other indicators are jitteriness, muscle stiffness, sensitive to sound, feeding and digesting difficulties, and poor sleeping patterns. Drug exposed infants should receive more than the standard medical follow-up. Follow-up interventions should include, but are not limited to nutrition need assessment, vision/hearing screening, speech/language assessments, physical therapy, and early educational need assessments. For children over twelve months of age who continue to experience complications refer to the section titled "older children who qualify as medically fragile " page 8.

iii. Fetal Alcohol Spectrum Disorder

Fetal alcohol spectrum disorder is a disorder seen in babies born to women who consume alcohol during pregnancy. This disorder results in changes in growth and physical appearance of the infants. It is suggested that the amount of damage that occurs to the infant is related to how early in the pregnancy the fetus was exposed to alcohol and how much the mother consumed. Alcohol exposure during pregnancy is a primary cause of birth defects and developmental delays. Children with fetal alcohol spectrum disorder may have a slower growth rate than other children, have facial abnormalities, and have problems with their central nervous system, including mental retardation.

Any or all of the following may be complications/symptoms of fetal alcohol spectrum disorder. All symptoms may not appear in every child with fetal alcohol spectrum disorder.

- poor growth rate.
- jittery, irritable, rigid, and extremely sensitive to sensory stimulation, especially sound.
- vomiting, dehydration, and diarrhea.
- feeding difficulties (poor sucking and swallowing).
- unable to establish regular routine for sleeping and waking.
- small head, narrow eyes, flat mid-face, low nasal ridge.
- developmental delays.
- muscle problems, bone and joint problems, heart defects, kidney defects.

iv. Hepatitis

Hepatitis is a condition in which the liver is inflamed. It is contracted from infected blood or blood products, and/or by sexual contact with an infected person. The inflammation prevents the liver from functioning properly, and could result in the “yellow jaundice” link to the hepatitis disease. Hepatitis B is most serious because it persists in the blood stream. Children with hepatitis B require special care primarily during the critical treatment phase and may qualify for medically fragile care.

Any or all of the following may be complications/symptoms of hepatitis. All symptoms may not appear in every child.

- lethargy
- irritability
- poor feeding
- fever
- jaundice
- rash or joint pain

v. Seizure Disorder

Epilepsy is not a diagnosis or a disease but rather a description of one symptom that is very ordinary in children who have experienced brain injury. Epilepsy has been referred to as “seizure disorder.” It is a chronic medical condition produced by temporary changes in the electrical functioning of the brain, causing seizures, which affect awareness, movement, and sensation. A seizure may result in convulsions, periods of unconsciousness or altered behavior. Infants and children with a seizure disorder must receive regular follow-up care to establish how well their medication is working and whether there are serious side effects. When the child’s physician or health care providers and the ISP team determines that the child’s seizure condition is stabilized and being controlled by medication, and there are no other special care needs, the child would not qualify for medically fragile care.

vi. Cystic Fibrosis

Cystic fibrosis (CF) is a life-shortening disorder that affects the way that salt and water move into body cells. It is one of the most common inherited disorders among Caucasians in the United States. The most significant effects of this condition are in the lungs and digestive system. The changes most often associated with CF involve the mucus producing glands, the sweat glands, and the glands, which secrete digestive fluids. Currently there is no cure for CF.

Any or all of the following may be complications/symptoms of cystic fibrosis. All symptoms may not appear in every child.

- persistent coughing and/or recurring wheezing
- recurring pneumonia or other respiratory infections
- difficult, rapid breathing
- nasal polyps
- excessive hunger with poor weight gain
- salty tasting skin
- distended abdomen
- bulky, greasy, foul smelling bowel movements
- chronic diarrhea

vii. Traumatic Brain Injury

Traumatic brain injury (TBI) occurs from a fracture or penetration of the skull. Traumatic brain injuries are most often the result of the head impacting a hard surface which leads to brain swelling or bleeding around the brain within the skull. The damages can result in the vertebral column affecting the spinal cord's ability to send and receive messages from the brain to parts of the body that control motor, sensory, and autonomic functions. Symptoms of brain injury include:

- excessive sleepiness;
- inattention;
- impaired memory;
- depression;
- slowed thinking, and irritability;
- TBI can result in paralysis or loss of body control functions;
- Brain injuries can occur in children as a result of injuries sustained in a motor vehicle accident;
- bicycle accidents;
- falls;
- sporting injuries; and
- child abuse.

viii. Shaken Baby Syndrome

Forceful shaking of an infant/child causes shaken baby syndrome. This vigorous shaking can result in brain damage leading to mental retardation, speech and learning disabilities, paralysis, seizures,

hearing loss, and even death. The victims of shaken baby syndrome range in age from a few days old to five years old. As a result of being shaken, children may show signs of a variety of disabilities, including partial or complete loss of vision, hearing impairments, seizure disorders, cerebral palsy, sucking and swallowing disorders, developmental disabilities, autism, cognitive impairments, behavior problems and permanent vegetative state.

ix. Hemophilia

People with hemophilia, known as hemophiliacs or free bleeders, bleed longer because their blood does not clot well. If proper treatment is not received some hemophiliacs can bleed to death. Hemophilia is a genetic disorder that affects males of all races and ethnic backgrounds. It is rare for females to have hemophilia. Children with hemophilia may be medically fragile because of the volatile condition that can require sudden specialized care and treatment.

x. Sickle Cell Anemia

Sickle cell anemia is an inherited, chronic disease in which the red blood cells, normally disc-shaped, become crescent shaped. These cells function abnormally and cause small blood clots. (Having sickle cell trait only does not qualify for medically fragile care.)

Sickle cell anemia is present at birth; however; symptoms do not occur until after four months of age. Sickle cell anemia can become life threatening when damaged red blood cells break down, when the spleen enlarges and traps the blood cells, or when a certain type of infection causes the bone marrow to stop producing red blood cells.

Any of the following may be symptoms of sickle cell anemia:

- joint pain, bone pain;
- abdominal pain;
- fatigue;
- fever;
- breathlessness;
- rapid heart rate;
- delayed growth;
- susceptibility to infections;
- bloody urine or excessive urination; and
- poor eyesight/blindness.

xi. Autism

Children develop autism as a result of a genetic predisposition (dealing with multiple genes), environmental insult, or insult to the developing brain prior to age three years. Autism is most common in males and appears early in life, usually before the age of three. Autism is characterized by deficits in language/communication, reciprocal social interactions, and abnormal behavior. Autism is also associated with neurological disturbances, gastrointestinal abnormalities, and immune dysfunction. Autism is, therefore, a biological disorder and is best described as “autistic spectrum disorder” because of its wide clinical spectrum.

The early signs of autism include social, behavioral, and communication concerns. Social concerns are:

- maintaining poor eye contact;
- appearing to be in their own world and unaffected by environmental stimuli; and
- preferring to play alone, uninterested in interacting with other children, and not smiling at appropriate social clues.

Behavioral disturbances include, but are not limited to:

- tantrums;
- lining things up;
- oversensitive to certain textures or sounds; and
- getting stuck on things over and over.

Communication concerns include, but are not limited to:

- not responding to their name;
- inability to verbally express their wants or needs;
- appearance that they may be deaf at times;
- does not point or wave good-bye;
- does not follow directions; and
- may have previously spoken a few words, but does not (cessation of language development).

Concerns that warrant immediate evaluation are:

- no babbling or gesturing by age twelve months;
- no single words spoken by age sixteen months;
- no two-word spontaneous phrases spoken by age twenty-four months; and

- any loss of any language or social skills at any age

There is no cure for autism but treatment can reduce symptoms and help people with autism function better. Treatment measures include medications, speech therapy, behavior modification, vitamin and mineral supplements, auditory training, and vision therapy.

xii. Diabetes Mellitus

Diabetes mellitus is a disease that has an effect on the body's capability to control the amount of glucose flowing in the blood. Children with Type I diabetes are usually insulin-dependent. In insulin dependent diabetes mellitus, the body fails to produce insulin; therefore, another source of insulin must be made available to regulate the amount of glucose in the blood. Type I is most common in children and adults younger than thirty. Caregivers of young children who have insulin dependent diabetics require special training to properly care for these children. The training should include appropriate storage and administration of insulin, recognition and treatment of hypo and hyperglycemia, meal planning, and urine and blood glucose measurement.

Diabetes mellitus Type I and II are serious diseases, which can pose threats to both the child's life and his/her developing sense of self. Successful diabetes supervision usually requires significant lifestyle modifications for the whole family. It is the care required by the child that will determine if a child with diabetes meets the requirements for medically fragile care.

Diabetes can directly cause serious life-threatening events. If diabetes is not treated properly, it can lead to numerous health complications which include heart disease, stroke, high blood pressure, blindness, kidney disease, nervous system disease, and dental disease. In addition, diabetes may result in the loss of limbs or death.

Any or all of the following may be complications to diabetes mellitus:

- frequent urination and increased amount of urine;
- weight loss, despite increased appetite and thirst;
- extreme tiredness or weakness;
- visual impairments, such as blurred vision; and
- infections which may involve the skin, vagina, bladder, or other areas
- pain, numbness or tingling in the hands and feet.

xiii. Serious Birth Diagnoses

Infants (0-12 months) diagnosed at birth with serious medical conditions require strict medical follow-up and/or frequent hospitalizations. Indicators of serious medical conditions include but are not limited to:

- Prematurity (32 weeks or less);
- Low birth weight (5 lbs. – 8 oz. or less);
- Low Apgar (6 or less);
- Intra Ventricular hemorrhage (IVH);
- Need for Ventilator at birth;
- Small for gestational age;
- Seizure disorders;
- Requiring Apnea monitors;
- Poor feeding capabilities; and
- Retinopathy.

xiv. Congenital Defects

Children diagnosed with serious medical conditions requiring strict medical follow-up may also be considered medically fragile. This list is not an all-inclusive listing.

- Congenital heart disease (birth defect that involves the heart or major blood vessels leading to and from the heart);
- Spina Bifida (birth defect in which the spine fails to close);
- Hydrocephalus with or without shunt (condition caused by abnormal buildup of cerebrospinal fluid in the ventricle of the brain);
- Microcephaly (head size is small in relation to the body size); and
- Cerebral Palsy with Complicating Conditions (term used to explain circumstances where there is loss of control of the voluntary muscles).

b. Older Children Who Qualify As Medically Fragile

Children over age three, who are without adequate self help skills to care for themselves can be considered medically fragile. These children require everyday tasks be completed for them such as grooming, bathing, toileting, feeding, dressing, ambulation, and positioning, administration of all medications and special therapies.

Children, any age, requiring specialized health care maintenance at home can be considered as medically fragile. The following are examples of conditions that may warrant medically fragile care in older children. It is not a comprehensive list and child welfare staff should consult with the Office of Permanency if there is a question of other possible qualifying conditions:

- Tracheotomy care;
- Gastronomy feeding and care;
- Broviac Catheter Intravenous Central Line Care;
- Apnea monitoring;
- Oxygen therapy;
- Dialysis;
- Bladder Catherization care;
- Burn care (for extensive skin and body damage);
- Wound care (depending on severity);
- Percussion therapy;
- Factor 8 infusion therapy (for hemophilia);
- Naso/gastric feeding;
- Terminal illness care; and
- Specialized sterilization practices.

When specialized medical care/treatment is no longer needed, the child is no longer eligible for medically fragile difficulty of care payment. This determination is made at the ISP team meeting. It is the responsibility of the social worker to obtain medical records from the medical providers to assist in the determination.

c. Children Who Are Not Medically Fragile

Children who exhibit any of the following characteristics but do not require special care cannot be classified as medically fragile.

- Developmentally delayed children with no serious medical or behavior problems requiring no special care.
- Children who are learning disabled, neurologically impaired, emotionally disturbed, socially maladjusted or perceptually impaired with no other needs for special care other than possible monitoring of medications.
- Children requiring ongoing psychological and psychiatric care with no other extraordinary care needs.
- Children who bed wet and soil with no other extraordinary care need other than monitoring medications.

- Blind or deaf children with no other extraordinary medical or care needs.
- Children, over the age of one (1) year, who had previously been diagnosed as suffering from failure to thrive but who are now experiencing no other qualifying medical difficulty.

d. Training And Requirements Of Foster Parents To Provide Medically Fragile Care

Foster parents must have met all pre-service basic training requirements for regular DHR foster family home approval in accordance with the Minimum Standards for Foster Family Homes. They must receive “disease or condition specific” instructions related to the condition of the child scheduled for placement in the home. They must also receive basic instruction in “infection control” (HIV providers primarily and others as appropriate). The county DHR shall maintain documentation of training or experience the foster parent has had in child specific disease/disabilities categories. The county DHR shall assist foster parents in obtaining specialized training as needed to provide care for specific children. There must be documentation that the foster parent has the training and ability to provide the care needed by the specific child.

A member of the foster family home or an approved back-up individual shall remain in the home with the medically fragile children, as many medically fragile children will be unable to attend daycare. The county department must approve any childcare arrangements involving a medically fragile child. If there is an unusual circumstance with the foster family provider, special approval for daycare may be granted.

A foster home providing care for medically fragile children shall not provide care for any more than two medically fragile foster children at a given time.

e. Payment Procedures

The majority of medically fragile children should qualify for Supplemental Security Income (SSI) disability benefits. Therefore, the caseworker must apply for SSI benefits as soon as the child is determined medically fragile and placed in the medically fragile foster family home.

The maximum monthly payment for providing medical fragile care (difficulty of care payment) is \$1114.00 per child, which includes the board payment. Award the standard age appropriate board payment on FACTS. The difference between the \$1114.00 medically fragile board rate and the board payment amount issued by FACT's will be paid from available funds as follows:

- If the child receives SSI, the county department will use these funds first. The SSI will be paid to the foster parent to make up the difference stated above. The description on the disbursement

authorization should read: Medically Fragile payment. If the child has SSI funds remaining after the above amount is paid to the foster parent, then these funds should be sent to SDHR for reimbursement of the board payment issued by FACTS.

- If the child receives SSI but the amount will not cover the entire difference stated above, the county will use the SSI first and use flex funds to complete the payment to the foster parents.
- If the child receives other funds (e.g., Social Security, etc.), the county department will use these funds to supplement the automated age appropriate board payment to reach the \$1114.00.
- In the case of a child who does not have private funds available, the county department will pay the foster parents from flex funds the difference between the automated board payment and the standard medically fragile rate of \$1114.00.

The county department will obtain a signed bill from the foster parent for the difference between the standard age appropriate board payment and \$1114.00. (See Forms Section for medically fragile billing form). Submit the signed bill according to local procedures for payment from county flex funds. Service authorizations and disbursements should indicate a service description of “medically fragile.”

f. **Medically Fragile Rate For Adoption Subsidies**

If a child is determined to meet the criteria for medically fragile care as a foster child, the child may qualify for the same rate for adoption subsidy. The county staff must make the determination, through the ISP process and according to the medically fragile policy that the child continues to require the level of specialized care prior to the adoption placement. A written request and recommendation from the county worker plus current supporting professional documentation of the need for a medically fragile rate for adoption subsidy must be sent to the State Office to the Office of Permanency for approval. Current supporting professional documentation is a letter of professional assessment (within the last three months) from the child’s attending physician (s) specifying the diagnosis and prognosis for the child and defining what specialized care and medical treatment the child requires of the foster/adoptive family.

The Office of Permanency must approve medically fragile rate of subsidy prior to subsidy agreement being signed.

Once the adoption is final, the adoptive family will need to provide supporting documentation from the child’s doctor (s), at time of the yearly subsidy re-certification, to continue to receive the medically fragile rate of subsidy. The documentation must address that the child’s condition

continues to require special care at the medically fragile level of care. When specialized care is no longer needed, as supported by documentation, the child is no longer eligible for the medically fragile rate of adoption subsidy. The amount of the adoption subsidy will be changed to the regular subsidy amount.

g. Data Entry

Children who have been determined eligible for medically fragile care, are coded on FACTS in the special needs field. The FACTS report for special needs children will incorporate medically fragile children.

3. HIV/AIDS

The following guidelines and information apply to the provision of services to a foster child who has AIDS, ARC or the HIV infection. HIV infected children are to be provided services as other foster children; however, due to their special circumstances, additional program guidelines are to be followed.

a. Testing Considerations

Testing for the HIV virus is to be viewed by the worker as a serious issue. The purpose of testing is to ensure that the child receives proper medical care; therefore, testing is appropriate only when there is a likelihood of HIV infection.

Test results have limitations. A positive test indicates the presence of antibodies. Screening for the HIV virus gives the status at a point in time and does not guarantee that the child will not later test positive. Pediatric AIDS cases are difficult to diagnose as it cannot be determined at birth whether an infant is actually infected. Some infants who test positive at birth will later test negative. Antibodies passed on to the fetus by an HIV infected mother may be present in infants up to 15 months of age but only 30 to 50% of these children are actually infected with the virus.

Because testing is a medical issue, testing for a child is not to be requested without the recommendation by the child's doctor in line with recognized risk factors. The medical decision to test is to be made on a case by case basis. Workers must be aware of the high-risk indicators of HIV infection and provide social history information to the doctor to assist him in making a decision concerning the child's need for testing. Circumstances that may put a child at an increased risk for the HIV infection are:

- Infants born to infected mothers or mothers at risk of infection. Factors to be considered which may place the mother at increased risk are: a history of intravenous drug abuse; sexual relations with a bisexual male or a male with a history of hemophilia or other coagulation disorders;

- Adolescents with a history of intravenous drug abuse or sexual intercourse with an intravenous drug user;
- Adolescents with a history of extensive sexual activity; and
- Adolescents with a history of hemophilia or other coagulation disorder.

Testing is not to be conducted without age and developmentally appropriate pre and post testing counseling by a counselor who has formal training in HIV infection. Counselors are available at the Public Health Department. The child's worker is not to provide this counseling but must be prepared to deal with the child's concerns about the test results.

For children in the temporary custody of the County Department under the age of 12, the County Department may consent to the testing. For a child under the age of 12 in care on an Agreement for Foster Care, the consent of the legal parent(s) must be obtained. The child 12 years old and older may consent to his own test in line with Section 22-11A-19, Code of Alabama 1975. If the child refuses, the worker will, upon medical advice, request that the court order the test to be done.

Retesting is to be requested as recommended by the child's physician and with appropriate consent.

b. Confidentiality

Information concerning a child's diagnosis of HIV infection is confidential and is to be handled with discretion. AIDS is a debilitating condition and children with AIDS or who are asymptomatic carriers of the AIDS virus are protected under Section 504 of the Rehabilitation Act of 1973. Disclosure of information must be made in accordance with this Act as outlines below.

For the child's best interest, people to be informed of the results of the testing must be kept to a minimum and on a need to know basis. The need to know is based on direct responsibility or accountability for the care of the child. People who provide direct care for the child need to be aware of this condition to ensure safety for the child and to ensure that infection control procedures are followed.

Agency personnel such as the social worker handling the case and homemakers offering direct services to the child are to be made aware of the HIV child's health status. Others who are always to be given the results of a positive test are: the child's private physician, dentist, the out-of-home care provider, the child's parent(s) and the AIDS Division of the State Health Department. The Health Department will be responsible for notifying the school when appropriate.

As stated above, the foster care provider must always be told when a child known to have AIDS, ARC or HIV infection is placed in their care. Referral

information to group homes and child care institutions should include information about a positive HIV test. The information about a positive HIV test shall be marked confidential. Remind them to carefully maintain confidentiality.

To lessen the potential for widespread knowledge of a child's HIV status through court proceedings, discuss with the Judge how to handle the sharing of information with the court.

c. Training and Education

Foster parents must receive education and training about the proper care and protection for an HIV infected or an at-risk child. This training should include information about HIV infections, its affect on children, measures to take to prevent transmission of the infection, and explanation of departmental policy on testing for children. At the time of approval or reapproval of the foster family home, in order to identify resources, ask foster parents if they will provide care for a child who has or may have AIDS, ARC or HIV infection.

It is the County Department's duty to offer and require training for any foster parent who provides care for a child who tests HIV positive or has AIDS. Document in the foster parent's record the date (s) foster parents attended the AIDS training.

d. Placement Considerations for Children Diagnosed with HIV Infection

Decisions concerning the most appropriate placement for the child should be made in consultation with the child's physician. Care should be provided in the least restrictive, most appropriate setting possible. Placement with parents and relatives are to be given the first consideration. In the selection of a foster care resource, the following factors should be considered: the ability to care for the child, the risk to other children, comfort level of caregiver, and the ability to maintain the child's/parent's right of confidentiality.

Obtain medical consultation on placement considerations if the child shows AIDS symptoms.

HIV infected school-age or pre-school children who lack control of body excretions, children who display biting behavior and children who have any type of oozing lesion that cannot be bandaged should be placed in a foster care setting that minimizes exposure to their blood or body fluids to other children. These children should be placed in a foster care setting that assures supervision by an adult caretaker at all times.

Adolescents who test positive for HIV infection or who have AIDS will be a group with special placement considerations. Important placement considerations are sexual promiscuity; IV drug use; health status; aggressive/assaultive behavior; running away episodes; emotional maturity; and social responsibility. If foster family care or related care is not

appropriate, then referrals to group care or residential treatment facilities are in order.

The out-of-home provider must be informed before the child is placed as to the child's medical condition and must have agreed to the placement. Prior to the placement of the child with foster parent(s), a face-to-face interview with them must be conducted with another worker or supervisor present. The purpose of the interview is to assure that the foster parent(s) understand the child's diagnosis, necessary precautions to avoid risk in providing care and have agreed to the placement. Document in the child's record and the foster parent's record the date and information provided as well as the names of the persons present.

e. Services During Placement

i. Services to the Child

An assessment by the worker should be completed to determine the need for specialized services and to make appropriate referrals. Services to be considered for inclusion in the ISP are: home health care which includes case management and respite care; specialized service fees; referral to and consultation from Children's Hospital; SSI application; Hospice; AIDS Outreach may be contacted for assistance. Because the child's medical condition can change drastically in a short period of time, the ISP should be reviewed at least every 3 months and more frequently if necessary.

HIV infected children must be afforded counseling on a level they can comprehend. The physician and parent(s) should have input in the decision as to how to tell the child about his condition. Initial and on-going counseling can be obtained from such sources as medical providers, supportive services from the child's worker, mental health professionals and public health personnel. Counseling should include specific information about the illness, and assistance in dealing with anger, fear and depression regarding the terminal nature of the illness.

Seek and rely on the child's doctor for specific information on medical care of the child, including immunizations and the need for hospitalization. Immunizations are of significance as vaccinations of infected children with live virus vaccines raise concerns. Close monitoring for problems with growth and development by the child's doctor is important as well as prompt medical treatment for potentially lethal infections.

Once a child is determined HIV infected or been given a diagnosis of AIDS, application should be made on behalf of the child for SSI. When the child becomes Medicaid eligible, an application should also be made for Medicaid waiver services, if appropriate. Those children will require extensive medical care and there will be

additional costs to the foster parents associated with caring for the child such as gloves.

ii. Services to the Foster Parents

Service will be needed to support and sustain the foster parents during the child's placement. In addition to supportive services from the worker, the foster parents may have a need for counseling on an individual basis or through a support group. Counseling may include infection control, dealing with stress of caring for an AIDS child and grief counseling.

Medical consultation will be important to the foster parents in managing the day to day health care of the child. Maintain open communication with foster parents and assist them in acquiring any services or equipment needed.

iii. Services to the Parents

Parents of a child with AIDS, some of whom may also be infected, should be provided an opportunity for counseling in dealing with issues related to AIDS. They are to be kept informed of the child's health status. Encourage parents to participate in medical appointments scheduled for the child.

Efforts to reunite the child with his family should be made as with any other child in out-of-home care. Even though the parent(s) may have AIDS or ARC, it may be possible, with supportive services, for the child to be reunited with them.

It is important that the parents maintain as much contact with their child as possible through visitation. As in all foster care cases, the parents need to have input in developing the child's ISP.

D. Health Insurance Portability and Accountability Act (HIPAA)

HIPAA requirements are complicated. Since the out-of-home care population requires that workers become substantially involved with health care matters of children in the department's care. HIPAA requirements are discussed in detail in the following section. Because they require completion of business associate agreements (a legal document), County Directors should become familiar with all of the policy/information documents listed.

During the ISP process, personal health information (PHI) on families and children is shared with ISP team members. HIPAA places restrictions on the use and disclosure of PHI and gives clients greater access to their medical records. An individual's identifiable PHI includes health information and demographic information that is created, received, and/or maintained in DHR case records. Any information that relates to an individual's past, present or future physical, or mental health or the provision of or payment for health care is considered PHI. PHI is also information that identifies an individual such as telephone number, address, etc.

HIPAA requires “covered entities” to guarantee that their business associates comply with HIPAA’s provisions by entering into business associate agreements. A “business associate” is any entity (person or organization) that participates, performs, or assists in the performance of a function or activity involving the use or disclosure of PHI. Due to the fact that DHR Family Services Child Welfare staff discloses PHI to other organizations and individuals, a HIPAA business associate agreement is required. County DHR departments will need to obtain business associate agreements from their local hospitals, mental health agencies, private therapist, foster parents, vendors, and QA team members. A one-time business associate agreement from a provider who serves several families covers all cases served without the need for individual authorizations for each case. Vendor providers (even when the vendor provider is also a contractor but provides services to families outside of the contract) shall have a business associate agreement signed to cover the non-contract services. Family service staff may disclose PHI to a business associate who performs a function or activity on behalf of, or provides a service to DHR families based on language in the business associate agreement.

The ISP process/activity qualifies as either treatment or business activity not requiring a HIPAA authorization form. However, a business associate agreement or an authorization from the client will be necessary for those non-DHR persons or organizations involved in the ISP process. Business activities include quality assessment and improvement activities. Treatment includes the provision, coordination, or management of health care or related services as well as consultations with other providers. These activities may occur during the ISP process. HIPAA authorization forms are not required to carry out treatment, payment, or health care operations for children in the department’s custody. However, authorization forms are needed from a parent/legal guardian when DHR will share PHI on non-DHR custodial children for purposes other than treatment.

HIPAA provides that when treatment, payment, or health (business) operation purposes are involved, no authorization is required except for psychotherapy notes and for marketing purposes. A psychotherapy note is defined as “notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session. Psychotherapy notes are **not** medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment, results of clinical test, and any summary or diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.” The federal explanation of what psychotherapy notes excludes provides the description of the type of information that is included in progress notes received from providers. Thus, progress notes from providers are not considered psychotherapy notes as defined in the federal definitions. The county departments should have obtained a business associate agreement from providers who are non-DHR persons/organizations involved in the ISP process. Business associate agreements and authorization forms obtained during the ISP process also meet the Medicaid Rehab HIPAA requirements and can be used for obtaining progress notes from Medicaid Rehab providers that are members of the ISP team.

Foster parents are considered providers for multiple cases; therefore, a business associate agreement with the foster parent is sufficient to cover their involvement in any case. Business associate agreements should be obtained from the foster parent at the initial approval. As long as the foster parent is in current approval status, no other business associate agreement is required.

Two versions of a standard DHR business associate agreement are located in the form section of this policy. One version has State DHR filled in and a space for the Commissioner's signature. This is the form that DHR lawyers are being asked to complete. This form can also be used for mental health agencies, hospitals, and other providers, which serve county departments. SDHR will use this version to obtain business associate agreements with other state departments and agencies. The second form is a blank business agreement which county departments can use to share information on a local level with routine members of the ISP teams such as foster parents, schools, etc. A copy of the DHR HIPAA Privacy Authorization form is also located in the form section of this policy and can be used for individual cases to authorize the disclosure of PHI by DHR staff and others. Some of the language has been filled in to assist staff in the completion of the form.

E. Consent of Minors for Health Care

1. Criteria for Minors to Consent (Code of Alabama, 1975 § 22-8-4, 22-8-5, and 22-8-6)

Generally, minors who meet any of the following criteria may consent to their own legally authorized medical, dental, health, or mental health services without the consent of any other person:

- They are fourteen (14) or older; or
- They have graduated from high school; or
- They are married; or
- Having been married, they are divorced or are pregnant.

Minors, regardless of age, may also give consent to legally authorized medical, dental, health or mental health services for their children when:

- Minors are married; or
- Having been married, they are divorced or have borne a child.

Minors may also consent to legally authorized medical, health or mental health services without the consent of any other person in order to determine the presence of or to treat the following conditions:

- Pregnancy;
- Venereal disease;
- Drug dependency;
- Alcohol toxicity; or
- Any reportable disease.

2. Contraception for Foster Children

Child welfare staff must refer to the *Family Planning Policy & Procedures* prior to any discussions with any foster child on contraception. It is not appropriate for child welfare staff to explain how various methods work or to recommend a particular birth control method to a child in out-of-home care.

When birth control is needed or requested by minor children in foster care, parental consent is desirable, but not necessary when criteria noted under section E-1 "Criteria for Minors to Consent" are met. If the child in out-of-home care is under age fourteen (14), parental consent must be obtained or the Juvenile Court motioned for a decision regarding consent.