

Working Together

HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

NYS Office of Children and Family Services

Appendix A

Forms and Websites

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NYS Office of Children and Family Services

Forms

The following sample forms are presented in the order in which they are referenced in the manual.

■ Chapter 1, Initial Evaluation of Child's Health

- **Admission Screening Interview:** This screening interview tool was designed for youth at the time of initial placement into OCFS Division of Juvenile Justice and Opportunities for Youth facilities. It may be adapted for use with children being placed in foster care..... 5
- **Health History Interview With Family:** This form may be used at any opportunity of contact with the child's family to record and update the child's health history. The Birth Family's Health History list corresponds with the Conditions list in the CONNECTIONS Bio Family Health tab. The form assists in collecting critical information for health services providers and for the child's medical record..... 7
- **Medical Review of Systems:** The Medical Review of Systems form can guide staff in obtaining a more thorough health history on the child from a family member or caregiver. It includes observations of the child's condition and behavior that may not be typically gathered by the health care practitioner but could prove very helpful. 13

■ Chapter 3, Special Health Care Services

- **Family Planning Notice:** This sample letter is used to inform youth age 12 and older of the availability of social, educational, and medical family planning services. 17

■ Chapter 4, Health Care Coordination

- **Health Care Coordination and Treatment Plan:** This form is used to record findings from the initial screening as well as the five assessments comprising the comprehensive health evaluation, during the first 30 to 45 days of the child's placement. 19
- **Health Discharge Summary:** This sample health discharge summary form may be used to record health activities when a child is discharged from foster care. 21

■ Chapter 5, Medication Administration and Management

- **Medication Log for Caregivers:** This form may be used to assist the caregiver in documenting the administration of medication. Both a blank form for replication and a sample form with entries displayed are included. 23
- **Informed Consent for Psychiatric Medication – Children in Foster Care:** This form provides information that supports the informed consent process and includes the medication monitoring plan and contact numbers. Use a separate form for each medication, and attach the drug information sheet. 27

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- **Guidelines for Voluntary Agencies Regarding Informed Medical Consent for Behavioral/Psychotropic Medication and Informed Medical Consent for Behavioral/Psychotropic Medication:** These Guidelines and accompanying Consent Form were developed by a group of local commissioners and voluntary agency directors to standardize and facilitate the communication process between them in regard to consent for psychiatric medications. The form is used when the agency has been unable to obtain an informed consent from the parent/guardian and is requesting consent from the LDSS commissioner. 29
- **Chapter 6, Medical Consents**
 - **Informed Consent to Perform HIV Testing (DOH-2556 and 2556i):** For a copy of the form, go to the NYS Department of Health website, www.health.state.ny.us, and click on HIV/AIDS. . This form is available in several languages.
<http://www.health.state.ny.us/diseases/aids/forms/informedconsent> 33
- **Chapter 7, Confidentiality of Health Information**
 - **Authorization for Release of Confidential HIV Related Information (DOH-2557, Rev. 8/05):** For a copy of the form, go to the NYS Department of Health website. This form is also available in Spanish.
<http://www.health.state.ny.us/diseases/aids/forms/informedconsent> 37
- **Chapter 8, Maintaining Health Records**
 - **Health History Interview With Family** (*see description under Chapter 1, p. Appendix A-2*)
- **Chapter 9, Working With Community Health Care Providers**
 - **Health Care Provider Visit Record:** This summary visit record form provides an efficient way for medical providers to document the findings of the health service visit. The person accompanying the child to the visit requests that the form is completed before leaving the provider’s office, and it is then placed in the child’s agency health file. 41
 - **Mental Health Care Provider Visit Record:** This summary visit record form may be used for visits to mental health providers. 43
 - **Service Agreement:** This is a suggested model for a service agreement, which agencies may adapt for their use. 45
 - **Application for Discrete Medicaid Rate:** This five-page form guides voluntary agencies in the development of an application for a Medicaid per diem rate for a special population. The accompanying two-page document describes the approval process..... 47

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SAMPLE ADMISSION SCREENING INTERVIEW

Source: NYS Office of Children and Family Services, Form DFY-1448

The purpose of this interview is to determine if a youth at admission has any health problems that require immediate medical attention. A "Yes" answer to any of the following questions must result in consultation with a physician, registered nurse, physician's assistant or, in the absence of medical staff, the facility director. These professionals shall determine if the youth must be personally seen by a medical professional before being placed in the general facility population.

Youth Name	Case Number	Date of Birth
		M____D____Y____
A. MEDICAL HISTORY		
1. Does the youth complain of pain or believe he/she is sick or in need of mental health or dental services?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
2. Is the youth being treated for a medical, dental, or mental health problem?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
3. Does the youth believe he/she has a sexually transmitted disease? Any communicable disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
4. Does the youth report any past hospitalizations for medical or mental health problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
5. Does the youth report any past history of suicidal thoughts or gestures?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
6. If the youth is a girl, does she believe she is pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	How long does she believe she has been pregnant? _____ # of Months Is she under medical care for the pregnancy? No Yes
7. Does the youth take prescription or non-prescription medication(s)?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes → Attach sheet if more than one.	Name of Medication: Dosage: Frequency of Administration: Date and Time of Last Dose:
8. Does the youth have head lice?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	What treatment was done?
9. Does the youth have food or medication allergies?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
10. Does the youth have any dietary requirements?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Explain:
11. Has the youth taken any street drugs or used alcohol within the past 24 hours?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Name of Drug: Amount Used: Mode of Use: Frequency Used: Date/Time of Last Use: Any Problems Indicated:

Sample Admission Screening Interview, continued

B. OBSERVATIONS	
1. Youth Behavior: Is the youth calm, frightened, intimidated, sweating, shaking, etc.?	Explain:
2. General Appearance: Is the youth clean, appropriately dressed, polite, cared for, etc.?	Explain:
3. Mental Status: Is the youth aware of his/her surroundings, under the influence of drugs or alcohol, exhibiting bizarre thoughts or speech, expressing suicidal or homicidal thoughts, able to communicate needs, etc.?	Explain:
4. Physical Condition: Does the youth exhibit any trauma markings, bruises, cuts, needle marks, abnormal gait, or other signs of recent injury?	Explain:
<p>NOTE: If trauma markings are evident, take or cause to be taken, color photographs of visible or reported trauma. All reports of alleged abuse or maltreatment must be reported to the State Central Register of Child Abuse and Maltreatment.</p>	
C. MEDICAL DISPOSITION	
Upon completion of your screening, a decision must be made as to where the youth will be placed:	Specify
<input type="checkbox"/> General Population	
<input type="checkbox"/> General Population with Restrictions	
<input type="checkbox"/> General Population with Referral for Health Services	
<input type="checkbox"/> Immediate Referral for Emergency Treatment	
D. INTERVIEWER INFORMATION	
Name	
Title	
Signature	
Date	
Time	

SAMPLE HEALTH HISTORY INTERVIEW WITH FAMILY

Name of Child:	Date of Birth: M___D___Y___
Birth Mother's Name:	Date of Birth: M___D___Y___
Is mother deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, cause of death:</i>	Date of Death: M___D___Y___
Birth Father's Name:	Date of Birth: M___D___Y___
Is father deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, cause of death:</i>	Date of Death: M___D___Y___
BIRTH FAMILY'S HEALTH HISTORY	
Does the parent, a biological relative of the parent, or a biological sibling of the child in foster care, have a history of the following? If yes, check in the box, and insert family member's relationship to the child.	
Health History of Parent, Biological Relative, Biological Sibling	Family Member's Relationship to Child
<input type="checkbox"/> Alcohol Abuse/Dependence	
<input type="checkbox"/> Allergies (<i>specify</i>)	
<input type="checkbox"/> Aneurysm	
<input type="checkbox"/> Asperger's Disorder	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Autism	
<input type="checkbox"/> Blind/Visually Impaired	
<input type="checkbox"/> Cancer (<i>specify</i>)	
<input type="checkbox"/> Celiac Disease	
<input type="checkbox"/> Cerebral Palsy	
<input type="checkbox"/> Cleft Lip or Palate	
<input type="checkbox"/> Cystic Fibrosis	
<input type="checkbox"/> Deaf/Hearing Impaired	
<input type="checkbox"/> Diabetes Type I	
<input type="checkbox"/> Diabetes Type II	
<input type="checkbox"/> Down Syndrome	
<input type="checkbox"/> Dwarfism	
<input type="checkbox"/> Eczema	
<input type="checkbox"/> Emphysema	
<input type="checkbox"/> Epilepsy/Seizure Disorder	
<input type="checkbox"/> Fragile X Syndrome	
<input type="checkbox"/> Gingivitis (periodontal disease)	
<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Hemophilia	
<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Hypertension (high blood pressure)	
<input type="checkbox"/> Kidney Disease	

Sample Health History Interview with Family, continued

Health History of Parent, Biological Relative, Biological Sibling	Family Member Name/ Relationship to Child
<input type="checkbox"/> Learning Disabled (<i>specify</i>)	
<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Lupus	
<input type="checkbox"/> Mental Illness (<i>specify</i>)	
<input type="checkbox"/> Mental Retardation	
<input type="checkbox"/> Migraines	
<input type="checkbox"/> Motor Delay/Impairment	
<input type="checkbox"/> Multiple Sclerosis	
<input type="checkbox"/> Muscular Dystrophy	
<input type="checkbox"/> Narcolepsy	
<input type="checkbox"/> Neurofibromatosis	
<input type="checkbox"/> Neurological Impairment	
<input type="checkbox"/> Obesity	
<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Pervasive Developmental Disorder	
<input type="checkbox"/> Prader-Willi Syndrome	
<input type="checkbox"/> Scleroderma	
<input type="checkbox"/> Scoliosis	
<input type="checkbox"/> Seizure Disorder/Epilepsy	
<input type="checkbox"/> Sensory Impairment	
<input type="checkbox"/> Sickle Cell Disease/Trait	
<input type="checkbox"/> Social/Emotional Delay/Impairment	
<input type="checkbox"/> Speech/Language Delay/Impairment	
<input type="checkbox"/> Spina Bifida	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Substance Abuse/Dependence	
<input type="checkbox"/> Tay-Sachs Disease	
<input type="checkbox"/> Tourette's Disorder/Syndrome	
<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Ulcer	
<input type="checkbox"/> Other (<i>specify</i>)	

CHILD'S HEALTH HISTORY						
Allergies [include symptom(s) and severity]:						
Food	Environmental			Medication		
Durable Medical Equipment (eyeglasses, hearing aids, etc.)::						
Immunization History (If documentation is presented):						
Type	Date	Date	Date	Date	Date	Date
Hepatitis A			X	X	X	
Hepatitis B				X	X	
DTaP (diphtheria, tetanus, pertussis)						
Hib (haemophilus influenza type b)						X
MMR (measles, mumps, rubella)			X	X	X	
Varicella (chicken pox)			X	X	X	
IPV (polio)						X
PCV7 (pneumococcal disease)						X
Rotavirus (gastroenteritis)				X	X	
Tdap (tetanus, diphtheria, pertussis)		X	X	X	X	
MCV4 (meningococcal disease)		X	X	X	X	
HPV (human papilloma virus)				X	X	
Influenza						
Other, specify						
Medications						
Name of Medication	Date Prescribed	Dosage and Frequency	Condition Treated	Prescribing Provider		

Sample Health History Interview with Family, continued

Health Providers and Medical Record Contacts (list Primary Care Provider first)		
Professional (MD, PA, etc.)	Address	Phone
Sleep habits: <input type="checkbox"/> normal <input type="checkbox"/> up & down all night <input type="checkbox"/> early awakening (e.g., 4 am) <input type="checkbox"/> trouble falling asleep <input type="checkbox"/> night terrors <input type="checkbox"/> bed-wetting or soiling	Diet: <input type="checkbox"/> regular <input type="checkbox"/> special (<i>If special, explain _____</i>) Likes: Dislikes:	
Medical History (include chronic medical conditions, serious injuries, surgeries, hospitalizations, and dates): 		
Current and recent health concerns: 		
Behavioral concerns (include sexual behavior and substance use): 		

SAMPLE MEDICAL REVIEW OF SYSTEMS

Source: Jewish Child Care Association

SKIN

- | | | | |
|---|---|--------------------------------|--|
| <input type="checkbox"/> No difficulty | <input type="checkbox"/> Eczema | <input type="checkbox"/> Acne | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Tattoos | <input type="checkbox"/> Birthmarks | <input type="checkbox"/> Burns | <input type="checkbox"/> Warts/lesions |
| <input type="checkbox"/> Excessive bruising | <input type="checkbox"/> Hair/nail problems | | |

Comments:

NEUROLOGICAL (nerves and brain)

- | | | |
|--|---|--|
| <input type="checkbox"/> No difficulty | <input type="checkbox"/> History of head injury | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Abnormal movements | <input type="checkbox"/> Tics or vocalizations |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Frequent/recurrent headaches | |

Comments:

VISUAL (eyes and vision)

- | | |
|---|---|
| <input type="checkbox"/> No difficulty | <input type="checkbox"/> Eyeglasses |
| <input type="checkbox"/> Crossed eyes or "lazy eye" | <input type="checkbox"/> Problems (pain, redness, itchiness, blurred) |
| <input type="checkbox"/> Corrective surgery | <input type="checkbox"/> Injuries |

Comments:

AUDITORY (ears and hearing)

- | | | |
|--|---|--|
| <input type="checkbox"/> No difficulty | <input type="checkbox"/> Chronic infections | <input type="checkbox"/> Surgery (tubes) |
| <input type="checkbox"/> Hearing devices | <input type="checkbox"/> Other (ringing in ears/hearing loss) | |

Comments:

NOSE AND SINUSES

- | | | |
|--|---|---|
| <input type="checkbox"/> No difficulty | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Cold/heat induced problems |
| <input type="checkbox"/> Nasal discharge | <input type="checkbox"/> Chronic nasal stuffiness | <input type="checkbox"/> Frequent sinus infections |
| <input type="checkbox"/> Nose injuries (fractures) | | |

Comments:

MOUTH AND THROAT

- No difficulty
- Recurrent tonsillitis
- Hoarseness
- Tonsils and/or adenoids removed

Comments:

DENTAL

- No difficulty
- Missing teeth
- Chipped teeth
- Orthodontia
- Toothache
- Cavities
- Painful swollen gums

Comments:

RESPIRATORY (breathing and lungs)

- No difficulty
- History of tuberculosis or positive TB test
- Smoking
- Frequent colds
- Chronic cough
- Recurrent pneumonia
- Asthma: *If child has asthma, ask the following questions:*
 - _____ Age of onset
 - _____ Last episode
 - _____ Medication
 - Triggers:* Physical/cold Dust
 - Pets Feathers
 - Exercise induced Emotionally induced
 - Illness induced

Comments:

CARDIOVASCULAR (heart, arteries and veins)

- No difficulty
- Heart murmur
- Heart surgery
- Palpitations
- Shortness of breath
- High blood pressure
- Family history of heart attack or stroke before age 40

Comments:

NUTRITIONAL (food and diet)

- Vegetarian
- Eating Disorder
- Food allergies
- Overweight
- Underweight
- Daily milk/formula intake _____ oz.
- Supplements _____

Comments:

Medical Review of Systems, continued

GASTROINTESTINAL (stomach and digestion)

- No difficulty
- Constipation
- Diarrhea
- Vomiting
- Indigestion
- Lactose intolerance
- Food intolerance
- Rectal bleeding
- Ulcer
- Anal itching
- Encopresis/soiling
- Recent weight loss/gain
- Describe appetite _____

Comments:

URINARY (kidneys and urine)

- No difficulty
- Bed-wetting
- Day-wetting
- Difficulty voiding
- Bladder/kidney infections
- Frequent urination

Comments:

ENDOCRINE (glands and hormones)

- No difficulty
- Does not tolerate heat well
- Does not tolerate cold well
- Jittery
- Poor growth
- Thirsty all the time

Comments:

MUSCULOSKELETAL (muscles and bones)

- No difficulty
- Scoliosis
- Joint/muscle pain/swelling
- Congenital deformities (toes, fingers, etc.)
- Back pain
- Sports injuries (fractures)
- Gait abnormalities
- Frequent broken bones (more than 3 times)

Comments:

SLEEP

- No difficulty
- Sleep pattern difficulties
- Night walking
- Nightmares
- Difficulty falling asleep
- Solutions _____

Comments:

FEMALE GENITAL SEXUAL HISTORY

- Date menarche began M__D__Y__
- Average length of period ____ Days
- Breast lumps Nipple discharge
- Last GYN/Breast exam M__D__Y__
- Number of pregnancies ____
- Number of miscarriages ____
- Previous HIV testing M__D__Y__
- Last menstrual period M__D__Y__
- Menstrual cramps
- Vaginal discharge
- STDs (type_____)
- Number of abortions ____
- Number of live births ____
- Contraception_____

Comments:

MALE GENITAL SEXUAL HISTORY

- Last testicular exam M__D__Y__
- Hernia
- Penile discharge
- STDs (type_____)
- Contraception_____
- Pain in penis/testicles
- Penile sores/lesions
- Lumps on or near testicles
- Previous HIV testing M__D__Y__

Comments:

HEMATOLOGY (blood)

- No difficulty Anemia Bleeding problems
- Abnormal lumps or bumps (enlarged lymph nodes)

Comments:

SEXUAL ABUSE SCREEN

- Has the child ever had an unwanted sexual experience? Yes No
- Sexual Activity: Inactive Single partner Multiple partners
- Same sex Opposite sex

Comments:

SUBSTANCE ABUSE SCREEN

- History of use: Cigarettes Marijuana Alcohol Other drugs_____

Comments:

SAMPLE FAMILY PLANNING NOTICE

Source: Association to Benefit Children, Variety Cody Gifford House

Date:

Dear:

I am writing you this letter to encourage you to set up an appointment with me in order to discuss **Family Planning Services and Human Sexuality**. I realize that not all adolescents are sexually active. However, even if you are not sexually active, you are entitled to have this information and to have someone that you can talk to about these issues, privately.

If, for some reason, you are unwilling to do so, I am including a packet of information on places for you to go in order to receive these services. This packet also includes reading material related to human sexuality and safety. If you decide to use any of the services offered, please let me know if it was helpful so that I can recommend it to other youth – or not.

Don't be surprised if you receive this same request and the same packet every six months. We would rather be persistent than forgetful when it comes to your health and safety.

Sincerely,

Your foster care nurse

SAMPLE HEALTH CARE COORDINATION & TREATMENT PLAN (30-45 Days)

Source: Kinship Family and Youth Services

Name of Child:		Date of Birth: M ___ D ___ Y ___	Date Placed: M ___ D ___ Y ___
INITIAL SCREENING (24 HOURS)			
Appt. Date: M ___ D ___ Y ___		Where/With Whom	
Date Completed: M ___ D ___ Y ___			
Follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: M ___ D ___ Y ___		Instructions	
COMPREHENSIVE HEALTH EVALUATION			
Medical Assessment (includes physical exam, vision, hearing, other screening tests)			
Appt. Date: M ___ D ___ Y ___		Where/With Whom	
Date Completed: M ___ D ___ Y ___			
Follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: M ___ D ___ Y ___		Instructions	
Dental Assessment			
Appt. Date: M ___ D ___ Y ___		Where/With Whom	
Date Completed: M ___ D ___ Y ___			
Follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: M ___ D ___ Y ___		Instructions	
Mental Health Assessment			
Appt. Date: M ___ D ___ Y ___		Where/With Whom	
Date Completed: M ___ D ___ Y ___			
Follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: M ___ D ___ Y ___		Instructions	
Developmental Assessment			
Appt. Date: M ___ D ___ Y ___		Where/With Whom	
Date Completed: M ___ D ___ Y ___			
Follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: M ___ D ___ Y ___		Instructions	
Substance Abuse Assessment			
Appt. Date: M ___ D ___ Y ___		Where/With Whom	
Date Completed: M ___ D ___ Y ___			
Follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: M ___ D ___ Y ___		Instructions	
HEALTH CONCERNS			
Physical			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___
Dental			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___

Sample Health Care Coordination & Treatment Plan (30-45 Days), continued

Developmental			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___ M ___ D ___ Y ___ M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___ M ___ D ___ Y ___
Substance Abuse			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___ M ___ D ___ Y ___ M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___ M ___ D ___ Y ___
Medications			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___ M ___ D ___ Y ___ M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___ M ___ D ___ Y ___
Nutrition			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___ M ___ D ___ Y ___ M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___ M ___ D ___ Y ___
Sexuality Education			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___ M ___ D ___ Y ___ M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___ M ___ D ___ Y ___
Other			
Date Identified: M ___ D ___ Y ___	Summary of Issue	Intervention Plan	Dates Reviewed: M ___ D ___ Y ___
<input type="checkbox"/> Active <input type="checkbox"/> Stable			M ___ D ___ Y ___ M ___ D ___ Y ___ M ___ D ___ Y ___
Date Resolved: M ___ D ___ Y ___			M ___ D ___ Y ___ M ___ D ___ Y ___

SAMPLE HEALTH DISCHARGE SUMMARY

Name of Child:	Date of Birth: M___D___Y___
Date Placed with Agency: M___D___Y___	Date of Discharge: M___D___Y___
PRIMARY CARE PHYSICIAN	
Name:	
Address:	
Phone:	
Last Seen: M___D___Y___	Reason:
Findings:	
SPECIALISTS	
<p>Dentist: Address/Phone:</p> <p>Last Seen: M___D___Y___ Reason: Findings: Next Appointment: M___D___Y___</p> <p>Other Specialist: Address/Phone:</p> <p>Last Seen: M___D___Y___ Reason: Findings: Next Appointment: M___D___Y___</p> <p>Other Specialist: Address/Phone:</p> <p>Last Seen: M___D___Y___ Reason: Findings: Next Appointment: M___D___Y___</p>	<p>Mental Health Provider: Address/Phone:</p> <p>Last Seen: M___D___Y___ Reason: Findings: Next Appointment: M___D___Y___</p> <p>Other Specialist: Address/Phone:</p> <p>Last Seen: M___D___Y___ Reason: Findings: Next Appointment: M___D___Y___</p> <p>Other Specialist: Address/Phone:</p> <p>Last Seen: M___D___Y___ Reason: Findings: Next Appointment: M___D___Y___</p>

Sample Health Discharge Summary, continued

OUTSTANDING MEDICAL ISSUES			
Explain:			
MEDICATIONS AT DISCHARGE			
Name	Dosage	Purpose	Prescribed By
INSURANCE			
Insurance coverage after discharge:			
SIGNATURES			
Testament	<input type="checkbox"/> have received a copy of the Health Discharge Summary.		
Name of Parent/Guardian			
Signature of Parent/Guardian			
Date			

GUIDELINES FOR VOLUNTARY AGENCIES REGARDING INFORMED MEDICAL CONSENT FOR BEHAVIORAL/PsYCHOTROPIC MEDICATION

Purpose: The purpose of these guidelines is to describe when and how to obtain informed medical consent for behavioral/psychotropic medication recommended for children in foster care following admission to a voluntary agency.

For detailed information about medications and the informed medical consent process, see the NYS Office of Children and Family Services manual “Working Together: Health Services for Children in Foster Care,” Chapters Five and Six. The manual is available on the OCFS website at http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp. Refer also to the Informational Letter 08-OCFS-INF-02 “The Use of Psychiatric Medications for Children and Youth in Placement; Authority to Consent to Medical Care” at <http://www.ocfs.state.ny.us/main/policies/external/>.

Obtaining Informed Medical Consent For Behavioral/Psychotropic Medication From the Parent/Legal Guardian:

- Voluntary agency staff are expected to enable parents/legal guardians who maintain legal guardianship to have the opportunity to provide informed medical consent; for example, encouraging their participation in medication review meetings and accompanying their children to medical appointments.
- If the parent/legal guardian who maintains legal guardianship is not present when a recommendation is made to begin or to change a prescribed psychotropic/behavioral medication, agency staff will contact the parent/legal guardian via phone calls, home visits, and letters to request their providing informed medical consent. Assistance from the LDSS caseworker may be requested as needed. This form is to be used when there is a new medication prescribed or a change that is outside the parameters of the previously approved dosage range, or when a child/youth is surrendered or freed for adoption.
- When the parent/legal guardian who maintains legal guardianship signs the voluntary agency’s informed medical consent form, agency staff will document, in a progress note in the CONNECTIONS case management system, the recommendation of the prescribing practitioner and that parental/legal guardian informed medical consent has been obtained.

When To Obtain Informed Medical Consent For Behavioral/Psychotropic Medication From the Local Department Of Social Services:

Note: The local district of social services (LDSS) is not authorized by NY State regulation to sign consents for PINS and JD youth or children placed in foster care by voluntary agreement.

When a child in foster care is freed for adoption, either through surrender or termination of parental rights, the LDSS or voluntary agency with **guardianship** has full authority to consent to any medical care or procedure. LDSS is authorized to sign consents for children removed under Article 10 (abuse or neglect) or placed by a court in the custody of the LDSS under Article 10.

- When a parent/legal guardian who maintains legal guardianship **cannot be contacted** or refuses to consent, the voluntary agency may seek informed medical consent from the LDSS. Agency staff will document, in a progress note in the CONNECTIONS case management

system, the recommendation of the prescribing practitioner and that parental/legal guardian informed medical consent has not been obtained.

- In the event a parent/legal guardian rescinds their consent, or their **right to provide informed medical consent is surrendered or terminated**, **AND** the parent/legal guardian had previously provided informed medical consent for behavioral/psychotropic medication, the voluntary agency must request *new* informed medical consent from LDSS for any behavioral/psychotropic medication the child is currently prescribed.

How To Obtain Informed Medical Consent For Behavioral/Psychotropic Medication From the Local Department Of Social Services:

A specific form has been designed to facilitate communication between voluntary agencies and local departments of social services when informed medical consent for behavioral/psychotropic medication is requested of them. Called the ***Informed Medical Consent For Behavioral/Psychotropic Medication**** form, it is a tool to provide comprehensive information to the LDSS.

- Voluntary agency staff will forward the completed ***Informed Medical Consent For Behavioral/Psychotropic Medication**** form, with all accompanying documentation, to the LDSS caseworker. The information will be presented by LDSS staff to the Commissioner of Social Services or his/her designee for a decision. The supporting documentation will be maintained in the LDSS case file. The LDSS will respond to the voluntary agency's request in a timely manner.
- In the event a child is justifiably **absent** from the voluntary agency (e.g., psychiatrically hospitalized, medically hospitalized, remanded or detained) **and** has not been discharged from the agency; **AND** the LDSS provides informed medical consent for a *new* behavioral/psychotropic medication, using the ***Informed Medical Consent For Behavioral/Psychotropic Medication**** form, LDSS staff are responsible for providing to the voluntary agency a copy of the IMC prior to the child's return to them. LDSS staff will document, in a progress note in the CONNECTIONS case management system, the recommendation of the prescribing practitioner and that informed medical consent has been obtained and a copy given to the voluntary agency.
- In the event a child is **discharged** from a voluntary agency and is being placed in another voluntary agency, LDSS staff will arrange for copies of any ***Informed Medical Consent For Behavioral/Psychotropic Medication*** form currently in effect to be provided to the receiving voluntary agency.

NOTE:** The ***Informed Medical Consent For Behavioral/Psychotropic Medication form is not required for non-behavioral/psychotropic medications or over the counter medications.

INFORMED MEDICAL CONSENT FOR
BEHAVIORAL/PSYCHOTROPIC MEDICATION**

Youth's Name: _____ DOB: _____ CIN# _____
(optional)
Agency Name: _____ Date of Request: _____
Contact: _____ Title/Role: _____
PH: _____ FAX: _____

Prescribing Practitioner (print name and title) _____
has recommended the above-named youth be placed on the following medication.

Medication: _____ With a dosage range of: _____

Check one of the following New medication Change to current medication
 Change in guardianship

Diagnosis to be treated (not diagnostic code): _____

This is recommended because: _____

_____ **AND**

with the expected outcome of: _____

The following **required** documentation/information or summary report (including this information) is attached as indicated by the check marks:

- | | |
|--|---|
| <input type="checkbox"/> names of participants involved
in the decision-making | <input type="checkbox"/> list of current medications |
| <input type="checkbox"/> results of monitoring current medications
(including side effects) | <input type="checkbox"/> current findings
(i.e. practitioner's status report including
alternative approaches undertaken) |
| <input type="checkbox"/> patient education efforts | <input type="checkbox"/> Drug Fact Detail Sheet |

Please note number of pages you are attaching to this form: _____

Signature of **approval**: _____ Date signed: _____

Relationship to youth: _____ County: _____

***This form is to be used when there is a new medication prescribed or a change that is outside the parameters of the previously approved dosage range; or when a child/youth has been surrendered or freed for adoption .
Use a separate form for each medication.*

Revised 11/21/05

Important Phone Numbers

New York State HIV/AIDS Hotlines (toll-free)

Call the Hotlines for information about HIV and AIDS and to find HIV testing sites

- 1-800-541-AIDS (2437) • English
- 1-800-233-SIDA (7432) • Spanish

New York State TTY/TTD HIV/AIDS Information Line

- 1-212-925-9560

Voice callers use the NY relay:

- 711 or 1-800-421-1220 and ask the operator for: 1-212-925-9560

New York State HIV/AIDS Counseling Hotline

- 1-800-872-2777

NYSDOH Anonymous HIV Counseling and Testing Program

For HIV information, referrals, or information on how to get a free, anonymous HIV test, call the Anonymous HIV Counseling and Testing Programs.

- Albany Region 1-800-962-5065
- Buffalo Region 1-800-962-5064
- Nassau Region 1-800-462-6785
- New Rochelle Region 1-800-828-0064
- Queens Region 1-800-462-6785
- Rochester Region 1-800-962-5063
- Suffolk Region 1-800-462-6786
- Syracuse Region 1-800-562-9423

NYCDOHMH HIV/AIDS Hotline: 1-800-TALK-HIV (1-800-825-5448)

New York State PartNer Assistance Program: 1-800-541-AIDS

New York City Contact Notification Assistance Program: 1-212-693-1419

Confidentiality

- New York State Confidentiality Hotline 1-800-962-5065
- Legal Action Center 1-212-243-1313 or 1-800-223-4044

Human Rights/Discrimination

- New York State Division of Human Rights 1-800-523-2437
- New York City Commission on Human Rights 1-212-306-7500

DOH-25566 (6/05) page 4 of 4

Informed Consent to Perform HIV Testing

HIV testing is voluntary. Consent can be withdrawn at any time by informing your provider. Please read Parts A and B of this form, and sign at the bottom of Part B, if you understand the following information and want HIV testing.

HIV infection is a serious health concern.

The New York State Department of Health recommends HIV testing. For pregnant women, the Department recommends HIV testing early in pregnancy and again late in pregnancy.

Except for expedited HIV testing on labor units, this form replaces other HIV testing consent forms as of June 1, 2005.

NOTE: this form is intended to be used in conjunction with DOH-2556, Part B.

DOH-25566 (6/05) page 1 of 4

Part
A

HIV is the virus that causes AIDS.

- HIV is passed from one person to another during unprotected sex (vaginal, anal or oral sex without a condom) with someone who has HIV.
- HIV is passed through contact with blood as in sharing needles (piercing, tattooing or injecting drugs of any kind) or sharing works with a person who has HIV.

The only way to know if you have HIV is to be tested.

- HIV tests are safe. They involve collecting one or more specimens (blood, oral fluid, urine).
- Your counselor or doctor will explain your test result as well as any other tests you may need.

Your HIV test today includes:

- A test to see if you have HIV infection (an antibody test or a test for the virus);
- If you are HIV positive, additional tests may include tests to:
 - help your doctor decide the best treatment for you.
 - help guide the health department with HIV prevention programs.

Several testing options are available.

- You can choose to have a confidential test where the result becomes part of your medical record and can be given to your health care provider for HIV and other health care services, or
- You can choose to have an anonymous test, which means that you don't give your name and no record is kept of the test result. If your anonymous test is HIV-positive, you can choose to give your name later so you can get medical care more quickly.
- To get more information about options for testing and free or anonymous testing sites, ask your counselor/doctor or call 1-800-541-AIDS.

HIV testing is important for your health.

- If your test result is negative, you can learn how to protect yourself from being infected in the future.
- If your test result is positive:
 - You can take steps to prevent passing the virus to others.
 - You can receive treatment for HIV and learn about other ways to stay healthy. As part of treatment, additional tests will be done to determine the best treatment for you. These tests may include viral load and viral resistance tests.

00H-25561 (6/05) page 2 of 4

HIV testing is especially important for pregnant women.

- An infected mother can pass HIV to her child during pregnancy or birth or through breastfeeding.
- It is much better to know your HIV status before or early in pregnancy so you can make important decisions about your own health and the health of your baby.
- If you are pregnant and have HIV, treatment is available for your own health and to prevent passing HIV to your baby. If you have HIV and do not get treatment, the chance of passing HIV to your baby is one in four. If you get treatment, your chance of passing HIV to your baby is much lower.
- If you are not tested during pregnancy, your provider will recommend testing when you are in labor. In all cases, your baby will be tested after birth. A positive test on your baby means that you have HIV and your baby has been exposed to the virus.

If you test positive:

State law protects the confidentiality of your test results and also protects you from discrimination based on your HIV status.

- In almost all cases, you will be asked to give written approval before your HIV test result can be shared.
- Your HIV information can be released to health providers caring for you or your exposed child; to health officials when required by law; to insurers to permit payment; to persons involved in foster care or adoption; to official correctional, probation and parole staff; to emergency or health care staff who are accidentally exposed to your blood; or by special court order.
- The names of persons with HIV are reported to the State Health Department for tracking the epidemic and for planning services.
- The HIV Confidentiality Hotline at 1-800-962-5065 can answer your questions and help with confidentiality problems.
- The New York State Division of Human Rights at 1-800-523-2437 can help if you think you've been discriminated against based on your HIV status.

Your counselor/doctor will talk with you about notifying your sex or needle-sharing partners of possible exposure to HIV.

- Your partners need to know that they may have been exposed to HIV so they can be tested and get treated if they have HIV.
- If your health care provider knows the name of your spouse or other partner, he or she must report the name to the health department.
- Health department counselors can help notify your partner(s) without ever telling them your name.
- To ensure your safety, your counselor or doctor will ask you questions about the risk of domestic violence for each partner to be notified.
- If there is any risk, the Health department will not notify partners right away and will assist you in getting help.

00H-25561 (6/05) page 3 of 4

Informed Consent to Perform HIV Testing

My health care provider has answered any questions I have regarding HIV testing and has given me written information with the following details about HIV testing:



- HIV is the virus that causes AIDS.
- The only way to know if you have HIV is to be tested.
- HIV testing is important for your health, especially for pregnant women.
- HIV testing is voluntary. Consent can be withdrawn at any time.
- Several testing options are available, including anonymous and confidential.
- State law protects the confidentiality of test results and also protects test subjects from discrimination based on HIV status.
- My health care provider will talk with me about notifying my sex or needle-sharing partners of possible exposure, if I test positive.

I agree to testing for the diagnosis of HIV infection. If I am found to have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

For pregnant women only:

In addition to the testing described above, I authorize my health care provider to repeat HIV diagnostic testing later in this pregnancy. I understand that my health care provider will discuss this testing with me before the test is repeated and will provide me with the test results. The consent to repeat diagnostic testing is limited to the course of my current pregnancy and can be withdrawn at any time.

Signature: _____ Date: _____
(Test subject or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Printed Name: _____

Medical Record #: _____

Except for expedited HIV testing on labor units, this form replaces other HIV testing consent forms as of June 1, 2005.

NOTE: this form is intended to be used in conjunction with DOH-2556i, Part A.

DOH-2556 (5/05)

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

New York State Department of Health

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

- I consent to disclosure of (please check all that apply):
- My HIV-related information
 - Both (non-HIV medical and HIV-related information)
 - My non-HIV medical information **

Information in the box below must be completed.

<p>Name and address of facility/person disclosing HIV-related and/or medical information:</p> <p>_____</p> <p>_____</p> <p>Name of person whose information will be released: _____</p> <p>Name and address of person signing this form (if other than above):</p> <p>_____</p> <p>_____</p> <p>Relationship to person whose information will be released: _____</p> <p>_____</p> <p>Describe information to be released: _____</p> <p>Reason for release of information: _____</p> <p>Time Period During Which Release of Information is Authorized From: _____ To: _____</p> <p>Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any:</p> <p>_____</p> <p>_____</p> <p>Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):</p> <p>_____</p> <p>_____</p>

<p>All facilities/persons listed on pages 1,2 (and 3 if used) of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize.</p>	
Signature _____	Date _____

*Human Immunodeficiency Virus that causes AIDS

** If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

**HIPAA Compliant Authorization for Release of Medical Information
and Confidential HIV* Related Information**

**Complete information for each facility/person to be given general medical information and/or HIV-related information.
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or (212) 480-2522 or the New York City Commission on Human Rights at **(212) 306-7500**. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name _____

Client/Patient Number _____

**HIPAA Compliant Authorization for Release of Medical Information
and Confidential HIV* Related Information**

**Complete information for each facility/person to be given general medical information and/or HIV-related information.
Attach additional sheets as necessary. Blank lines may be crossed out prior to signing.**

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

If any/all of this page is completed, please sign below:

Signature _____ Date _____

Client/Patient Number _____

SAMPLE HEALTH CARE PROVIDER VISIT RECORD

Source: Kinship Family and Youth Services

Name of Child:	Date of Birth: M ___ D ___ Y ___
Name of Foster Family:	Date of Visit: M ___ D ___ Y ___
Name of Provider:	
Provider Address:	
Reason for Visit:	
Outcome/Results (or Dx and Plan):	
Follow up/ Next Appointment	<input type="checkbox"/> None Needed <input type="checkbox"/> Date: M ___ D ___ Y ___ Time: ___ : ___ <input type="checkbox"/> am <input type="checkbox"/> pm
Signatures	
Health Care Provider	Name:
	Signature:
Attending with Child	
Birth Parent	Name:
	Signature:
Foster Parent	Name:
	Signature:
Staff	Name:
	Signature:

SAMPLE MENTAL HEALTH CARE PROVIDER VISIT RECORD

Source: Kinship Youth and Family Services

Name of Child:		Date of Birth: M____D____Y____	
Name of Foster Family:		Date of Visit: M____D____Y____	
Mental Health Care Provider:			
Provider Address:			
Type of Visit:	<input type="checkbox"/> Individual Therapy <input type="checkbox"/> Group Therapy <input type="checkbox"/> Initial Psychiatric Evaluation <input type="checkbox"/> Initial Psychological Evaluation	<input type="checkbox"/> Psychometric Assessment <input type="checkbox"/> Family Therapy <input type="checkbox"/> Psychological Consultation	
Reason for Visit:	<input type="checkbox"/> Initial <input type="checkbox"/> Follow up <input type="checkbox"/> Emergency (crisis)	<input type="checkbox"/> Medication <input type="checkbox"/> Drugs and Alcohol	
Medications/Dosage:			
Medication Change:			
Reason for Change:			
Desired Result/ Expected Timeframe:			
Follow up/ Next Appointment:		Date: M____D____Y____ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm	
Signatures			
Health Care Provider		Name:	
		Signature:	
Attending with Child			
Birth Parent		Name:	
		Signature:	
Foster Parent		Name:	
		Signature:	
Staff		Name:	
		Signature:	

SAMPLE SERVICE AGREEMENT

Provider and Agency
(Period: 00/00/00 – 00/00/00)

PARTIES TO THE AGREEMENT

Health Care Provider/Hospital located at: _____

Agency located at: _____

PURPOSES OF THE AGREEMENT

The expressed purpose of this Agreement is to facilitate access to comprehensive, coordinated health care services for children in the care of Agency.

RESPONSIBILITIES OF THE PARTIES

A. Provider agrees to:

1. Provide general medical services at Provider's location.
2. Include, at a minimum, the standards outlined in the schedule of examinations. In addition, the requirements of the local district and/or court orders will be met. Admission, discharge, transfer, and AWOL physicals will be completed according to the agency guidelines.
3. Provide the following services when such services are needed and requested:
 - 24-hour Emergency Medical Services at the Provider's Emergency Department.
 - Clinic services at the Provider's clinics.
 - In-patient hospitalization as required.
4. Make available staff members who are duly licensed, qualified, and privileged to render services as required by JCAHO standards.
5. Provide written information summarizing diagnosis, procedures, and treatment and further recommendations for each child. Where the child has been hospitalized on an inpatient basis, Provider agrees to provide ongoing information regarding the child's condition, recommendations, and discharge plans, as well as provide a written discharge summary following discharge from the hospital.
6. Coordinate medical services for child in such a manner as to minimize the number of visits to the clinic.
7. Inform and train Provider's staff regarding confidentiality and disclosure requirements of New York State statutes and regulations, including those provisions concerning HIV-related information, and agree to comply with such requirements.
8. Obtain payment for services by the agency directly or through the child's health insurance, Medicaid, parent, or legal guardian, as directed by the agency.

Service Agreement, continued . . .
Sample Service Agreement, continued

9. Provide a consistent primary care provider with whom the child can have an ongoing relationship.
10. Primary care providers and other providers, as appropriate, to participate in joint case conferences as requested by Agency.
11. Primary care provider and other providers, as appropriate, to discuss the child's needs with the foster parents and the biological parents (if available), so they have a clear understanding of their responsibilities in the child's care according to all applicable laws.

B. Agency agrees to:

1. Maintain a roster of personnel authorized to make referrals for emergency services and clinic appointments.
2. Provide the necessary and pertinent clinical information on the child being referred.
3. Provide appropriately signed consent forms for treatment. The parent or legal guardian of the child must sign consents for non-emergency, in-patient hospitalizations. Agency will assist Provider to obtain parental or guardian consent whenever such consent is required.
4. Provide or arrange for transportation to Provider.
5. Provide, when appropriate, a child care staff member or family member to accompany the child or remain with the child who has been hospitalized. Child care coverage and duration will be determined on a case-by-case basis.
6. Assist in identifying third party payers and provide all available insurance information to Provider.

This Agreement may be terminated by either party upon thirty (30) days written notice.

Executive Director Signature	Date
Agency Name	

President/CEO Signature	Date
Provider Name	

Application for Discrete Medicaid Rate

Please fill in below and return with a completed DOH-4224 NYS Department of Health *Medical Services Expenditure Distribution Sheet – General Care* (previous DSS 2660) or DOH 4225 NYS Department of Health *Medical Services Expenditure Distribution Sheet – Special Care* (previous DSS 2660-01) of your agency’s most recent reporting period’s medical services costs to the Office of Children and Family Services Regional Office. If you have an existing general care rate and are applying for a special population rate, submit your agency’s DOH-4224 of the last completed rate year if revisions were made to that form.

I. Agency Information

Agency Name: _____

Agency Address: _____

Contact Person: _____

Phone Number: _____

Agency MMIS ID #: _____

Proposed Program Size (Number of beds/slots) _____

II. Special Program Requested (Check one)

General

Special
AIDS
Boarder Babies
Maternity
Hard to Place
Therapeutic Boarding Home
Diagnostic
Special Other

Note: If you are applying for more than one separate rate, complete one application form for each program for which you are applying.

If you have questions about completing the DOH-4224 or DOH-4225 for budgeting purposes, please contact Robert Payne of the Department of Health (DOH) at 518-473-8910. Also, for approved Medicaid per diems, you are required to report actual expenditures and revenues as follows:

- A.) DOH’s financial reporting requirements – The details of your actual expenditures and revenues for all MA per diem programs must be reported annually to DOH as an electronic submission of the DOH-4224 and DOH-4225. If you need a User-ID, contact your agency’s Health Provider Network (HPN) Coordinator, or call Robert

Bureau of Waiver Management
Application for Discrete Medicaid Rate

Payne at (518) 473-8910. Also, if you need instructions regarding the use of the HPN system for submitting the DOH-4224 and DOH-4225, you should again contact Robert Payne at (518) 473-8910.

- B.) OCFS' financial reporting requirements - Your actual expenditures and revenues for all Medicaid per diem programs must be reported annually (in one combined cost center) to OCFS as part of your agency-wide Statewide Standards of Payment (SSOP) submission. The Standards of Payment manual and other information related to your SSOP submission is available at <http://www.ocfs.state.ny.us/main/rates/>. Questions may be emailed to ocfs.sm.ssop@ocfs.state.ny.us.

DOH Provider Manuals with policy and billing guidelines are available at: <http://www.emedny.org/ProviderManuals/ChildCare/index.html>

III. Narrative Justification

- A.) Provide a brief over of the agency including the types of programs provided and number of children served within each program area.
- B.) The ages and health background of the children for whom the program is targeted. This must include the clinical characteristics of the children as well as the level of severity and diagnostic categories.
- C.) Provide a description of the children's previous involvement in the child welfare system. For instance, do you anticipate that the children to be served in this program will have prior foster care placements. If so, what level of health care may have been provided and how do you anticipate continuing the treatment plan? If not, how do you intend on arranging for medical, dental, mental health, substance abuse and mental health assessments and on-going care.
- D.) The model of treatment, including the health care services, both routine and exceptional, which will be provided.
- E.) Provide a description of how the agency intends on coordinating the health care of the children within the program. This should also include a description of how the treatment plan will be integrated within the overall goals of each child while both in care and upon discharge from care.
- F.) Provide a description of how the agency addresses trauma for children within the program.
- G.) Provide a description of how the agency intends on developing and implementing individualized safety plans.
- H.) Provide a description of how the agency intends on offering behavioral support to children in the program.
- I.) Include a description of how each proposed staff person (both direct health care staff and administrative staff) support the service needs of the target population. This should also include how each staff will work together.
- J.) How you propose to meet the medical requirements of the Child Teen Health Program (CTHP) and the regulations and administrative directives of the Department of Health and the Office of Children and Family Services.
- K.) Include a description on how the agency intends on providing alcohol and substance abuse services.

III. Budget Justification

Please explain, next to each cost center, what is included in the dollar amount that you have for that cost center. Specify number of Full-time equivalents (FTE's) or service units (e.g. visits, encounters). Indicate, with as much specificity as possible, how and by whom these services have been/will be provided (e.g. salaried staff, contract, clinic, etc.). If possible, include letters of agreement/referrals with medical providers.

EXAMPLE: the program anticipates serving 50 children over the course of a year. Provide the number of physician visits, including initial assessments, routine well-child visits, discharge visits as well as any potential sick-child visits. If the agency intends on using a contract physician, indicate the number of visits and the fee for each visit (250 visits x \$100 per visit = \$25,000). If on the other hand, the physician is a salaried staff, then indicate the percent of the employees time devoted to serving the anticipated number of children by the annual salary (20% x \$150,000 = \$30,000).

- 01 - Physicians
- 02 - Psychiatrist
- 03a - Psychological Services
- 03b - Certified Social Workers
- 04 - Dental
- 05 - Specialists
- 06 - Nursing Services
- 07 - Medical Administration
- 08 - Medical Supplies & Equipment
- 09 - Medical Transportation
- 10 - Central Administration
- 11- Administrative Overhead
- 12 - Property
- 13 - Hospital/Clinical
- 16 - Number of Care Days

Answer the following questions:

1. How you calculated the proposed per diem.
2. What is the total number of bed/slots available for this program?
3. What percentage of occupancy did you apply against that figure?
4. When did/will the program start?

Note: Please be aware that the same care days amount that you utilized in calculating the 'Foster Care and Maintenance' portion of your budget must also be used in calculating your Medicaid per diem for this program.

IV. Special Population Approvals

If you are applying for AIDS, Boarder Babies, Maternity, Hard to Place, Therapeutic Boarding Home, Diagnostic rate, then answer the following questions.

1. How many children will this program serve?
2. How many care days?
3. What level of occupancy is expected?
4. What counties will this program draw from?
5. Who are the local contacts in each county to be served?
6. What is the total cost of the program?
7. What is the administrative cost of this program?
8. What is the administrative ratio of this program?
9. What is the untrended per diem?
10. How does this relate to other existing programs?
11. Has this agency exceeded its parameters in the general care program?
12. Could this program be operated within the expenditure levels of general care?
13. How many other foster care programs does this agency operate?
14. Why does this agency need this program?
15. Is it required by a directive of a LDSS?

**Voluntary Agency Health Services
New Medicaid Rates Approval Process**

- I. Voluntary Agency submits completed Application Package to Office of Children and Family Services (OCFS) Regional Office. Regional Office staff will review the health services program.

Application Package includes:

- Application for Discrete Medicaid Rate
- DOH-4224 – NYS Department of Health *Medical Services Expenditure Distribution Sheet – General Care*
Or
- DOH-4225 - NYS Department of Health *Medical Services Expenditure Distribution Sheet – Special Care*

- A. OCFS Regional Office forwards a copy of the completed application to the OCFS Bureau of Waiver Management (BWM) at:

Attention: Mimi Weber
Office of Children and Family Services
Bureau of Waiver Management
52 Washington Street, 337 North
Rensselaer, NY 12144

- II. The OCFS BWM will review the proposal and work with the voluntary agency to refine the proposal and to assess whether the application meets the standards and requirements of OCFS and DOH.

- III. OCFS will convene a panel of health professionals from relevant state agencies including the Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), Office of Mental Retardation and Developmental Disabilities (OMRDD), DOH, and OCFS to discuss the proposed health services. The panel may request additional information/clarification or may find the health proposal acceptable.

- A. If more information is requested, BWM will contact the applicant directly, in consultation with the Regional Office Staff.
- B. If no more information is requested, BWM will prepare the OCFS Transmittal Letter for the DOH Office of Health Insurance Programs (OHIP) with a copy to the DOH Bureau of Long-Term Care and Reimbursement (BLTCR).

Package will include:

- Transmittal Letter
- Application
- DOH 4224 or DOH 4225

**Bureau of Waiver Management (BWM)
PROCESSES & PROCEDURES**

- IV. DOH will review the fiscal information and will notify OCFS BWM of their findings.
 - A. If acceptable, DOH will forward necessary information to the Division of Budget (DOB).
 - B. If DOH finds the application unacceptable, they will contact OCFS BWM for further information. OCFS and DOH may contact the voluntary agency for further details.

- V. DOB reviews the request. If DOB has any concerns, DOB will contact BWM Representative from BLTCR and/or Mimi Weber for BWM. Upon DOB approval, DOH will notify the applicant, as well as OHIP and OCFS through the MMIS Transmittal Letter.

Timeframes: To facilitate prompt processing of rate requests, OCFS will make an initial assessment of the application within 4-6 weeks of receiving the proposal, and will continue to work with agencies as the proposals are refined.

Websites

Advocates for Youth

www.advocatesforyouth.org

Advocates for Youth, GLBTQ Youth

www.advocatesforyouth.org/glbtc

AIDS Treatment Data Network

www.atdn.org

Al-anon-Alateen

<http://www.al-anon.alateen.org/>

American Academy of Child and Adolescent Psychiatry (AACAP)

AACAP Policy Statements

http://www.aacap.org/cs/root/policy_statements/policy_statements

American Academy of Pediatrics (AAP)

<http://www.aap.org>

Foster Care

<http://www.aap.org/healthtopics/fostercare.cfm>

Medical Home

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

AAP periodicity schedule

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

Policies, Reports, Guidelines

<http://aappolicy.aappublications.org/>

American Professional Society on the Abuse of Children (APSAC)

www.apsac.org

Association for the Treatment of Sexual Abusers (ATSA)

www.atsa.com

Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents

www.brightfutures.org

Child Abuse Evaluation and Treatment for Medical Providers

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

Child Advocacy Resource and Consultation Center (CARCC)

www.nyscarcc.org

Child Welfare Information Gateway

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

Controlled Substances

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

Controlled Substances: Definition of Schedules

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

Denver Developmental Materials, Inc.

<http://www.denverii.com/>

Healthy People 2010

<http://www.healthypeople.gov>

I Wanna Know (American Social Health Association)

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

It's Your (Sex) Life (Kaiser Family Foundation)

www.itsyoursexlife.org

KidsHealth (Nemours Foundation)

<http://kidshealth.org/>

Growth and Development Charts

www.kidshealth.org/parent/growth/growth/growth_charts.html

MedlinePlus

<http://medlineplus.gov/>

Mental Health Association in New York State, Inc.

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

National Alliance for Drug Endangered Children

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

National Alliance on Mental Illness

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

National Child Traumatic Stress Network

http://www.nctsn.org/nccts/nav.do?pid=hom_main

National Institute for Health Care Management (NIHCM)

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

National Youth Anti-Drug Media Campaign

<http://www.theantidrug.com/>

New York City Immunization Registry

<http://www.nyc.gov/html/doh/html/cir/index.html>

New York Codes, Rules and Regulations (NYCRR)

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

New York State Citizen's Coalition for Children, Inc.

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

New York State Laws

<http://public.leginfo.state.ny.us/menugetf.cgi>

New York State Department of Health

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

Childcare Agency Provider Manual

<http://www.emedny.org/ProviderManuals/ChildCare/index.html>

Child Teen Health Plan

<http://www.emedny.org/ProviderManuals/EPSTDCTHP/index.html>

Early Intervention Program

http://www.health.state.ny.us/community/infants_children/early_intervention/

Electronic Medicaid System of New York State

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

HIV/AIDS

www.health.state.ny.us/nysdoh/aids/index

HIV Clinical Resource, AIDS Institute

www.hivguidelines.org

Immunization Information System (NYSIIS)

http://www.health.state.ny.us/prevention/immunization/information_system/

Immunization Schedule

http://www.health.state.ny.us/prevention/immunization/childhood_and_adolescent

Medicaid "Carveout" Prescriptions

http://www.health.state.ny.us/health_care/medicaid/program/carveout.htm

Newborn Screening Program

Wadsworth Center, New York State Department of Health

www.wadsworth.org/newborn

Resource Directory for Children with Special Health Care Needs

<http://www.health.state.ny.us/publications/0548.pdf>

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

<http://www.oasas.state.ny.us/index.cfm>

Fetal Alcohol Spectrum Disorders (FASD)

<http://www.oasas.state.ny.us/fasd/index.cfm>

Methamphetamine Clearinghouse

<http://www.oasas.state.ny.us/meth/index.cfm>

Prevention Programs (search)

<http://www.oasas.state.ny.us/preventionDirectory/index.cfm>

Treatment Providers (search)

<http://oasasapps.oasas.state.ny.us/portal/pls/portal/oasasrep.dynprovsearch.show>

New York State Office of Children and Family Services

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

Bridges to Health (B2H)

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

Health Services for Children in Foster Care

http://www.ocfs.state.ny.us/main/sppd/health_services/new.asp

Policies (Administrative Directives, Informational Letters, Local Commissioner Memorandum)

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

Reports

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

New York State Office of Mental Health

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

Clinic-Plus Program

http://www.omh.state.ny.us/omhweb/clinicplus/support_network/providers/guidance.html

Suicide Prevention, Education, and Awareness Campaign (SPEAK)

<http://www.omh.state.ny.us/omhweb/speak/index.htm>

Treatment of Children with Mental Health Disorders

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

New York State Office of Mental Retardation and Developmental Disabilities

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

Obesity Resource (Connect for Kids)

http://www.connectforkids.org/obesity_resource

Permanent Judicial Commission on Justice for Children

<http://www.courts.state.ny.us/ip/justiceforchildren/>

Safer Society Foundation, Inc.

www.saferociety.org

Sex, Etc. (Network for Family Life Education, State University of New Jersey at Rutgers)

<http://www.sexetc.org>

Sickle Cell Information Center

www.scinfo.org/index.htm

Statewide School Health Services Center

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

STD Treatment Guidelines

<http://www.cdc.gov/STD/treatment/default.htm>

Teenwire (Planned Parenthood Federation of America)

www.teenwire.org

U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA)

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

Caring for Every Child's Mental Health

<http://mentalhealth.samhsa.gov/child/default.asp>

Family Guide to Keeping Youth Mentally Health and Drug Free

<http://www.family.samhsa.gov/>

FASD

<http://www.fascenter.samhsa.gov/index.cfm>

National Clearinghouse for Drug and Alcohol Information

<http://ncadi.samhsa.gov/>

(search for Screening and Assessing Adolescents for Substance Use Disorders Treatment Improvement Protocol (TIP) Series 31 and Treatment and Adolescents with Substance Use Disorders TIP Series 32 from this screen)