

# Health Services for Children in Foster Care: Consent and Confidentiality

*January 30, 2007*

*1:30-3:30*

Handout Packet



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

New York State  
Office of Children and Family Services  
and  
SUNY Training Strategies Group

**HEALTH SERVICES FOR CHILDREN IN FOSTER CARE:  
CONSENT AND CONFIDENTIALITY**

**January 30, 2007**

**1:30pm – 3:30pm**

**TABLE OF CONTENTS**

<b>Glossary of Terms</b>	<b>Page 1</b>
<b>Custody and Guardianship</b>	<b>2</b>
<b>Consent for Routine Care</b>	<b>3</b>
<b>Region IV Guidelines</b>	<b>4</b>
<b>Region IV Form</b>	<b>6</b>
<b>CONNECTIONS AND HIPAA letter</b>	<b>7</b>
<b>97 ADM-15 Administrative Directive</b>	<b>10</b>
<b>Public Health Law 27-F</b>	<b>53</b>
<b>Summary of Statutes and Regulations</b>	<b>63</b>

## Glossary of Terms

**Capacity to Consent**- a minor's ability to understand and appreciate the nature and consequences of the proposed health care service, treatment or procedure, including the benefits and risks of, and alternatives to, such proposed service, treatment or procedure and to reach an informed decision. (MHL §33.21(a)(5))

**Comprehensive Health History**- includes, but is not limited to, conditions or diseases believed to be hereditary, where known; drugs or medication taken during pregnancy by the child's biological mother, where known; immunizations received by the child while in foster care and prior to placement in care, where known; medications dispensed to the child while in care and prior to placement in care, where known; allergies the child is known to have exhibited while in care and prior to placement in care, where known; diagnostic tests, including developmental or psychological tests and evaluations given to the child while in care and prior to placement in care, where known, and their results, laboratory tests for HIV, where known, and their results; and any follow-up treatment provided to the child prior to placement in care, where known, or provided to the child while in care, or still needed by the child. (18 NYCRR §357.3(b)(7))

**Guardianship**- legal authority and responsibility to act in the place of a parent, including but not limited to medical consents, schooling, and Do Not Resuscitate orders

**Informed Consent**- The person giving consent has been informed of the details of treatment, been given an explanation of the procedures to be followed, had the opportunity to ask questions, and understands the risks, benefits and alternatives of the treatment. Informed consent is for a specific treatment or procedure.

**Legal Custody**- temporary responsibility for the care of a child granted by the court

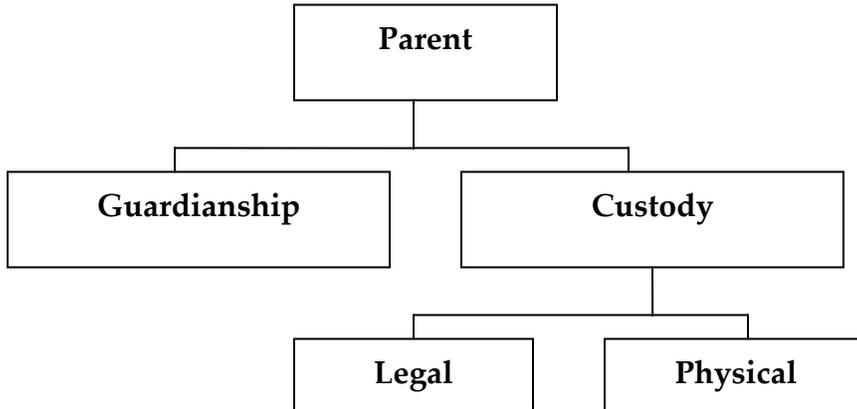
**Need to Know**- a person has a "need to know" confidential health information if he or she is unable to complete specific duties or responsibilities without the information

**Physical Custody**- temporary responsibility for the child's physical care, i.e. food, clothing, shelter.

**Right to Know**- a person has a "right to know" confidential health information if such right is described in a statute or regulation

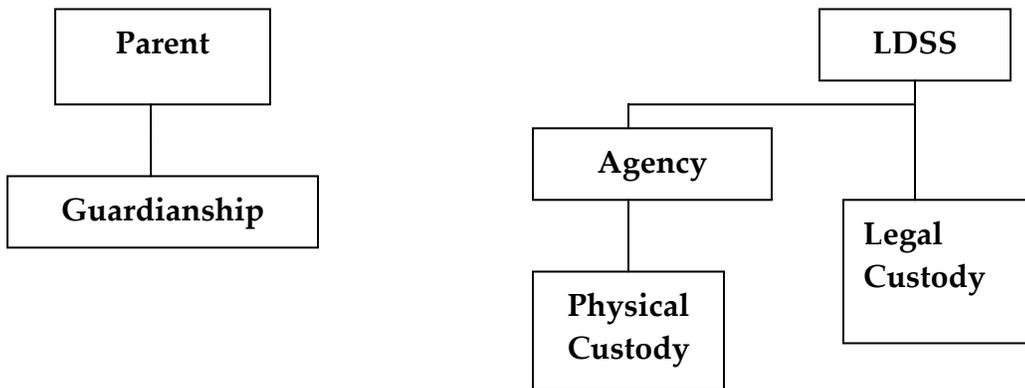
# Custody and Guardianship

## Child Is At Home



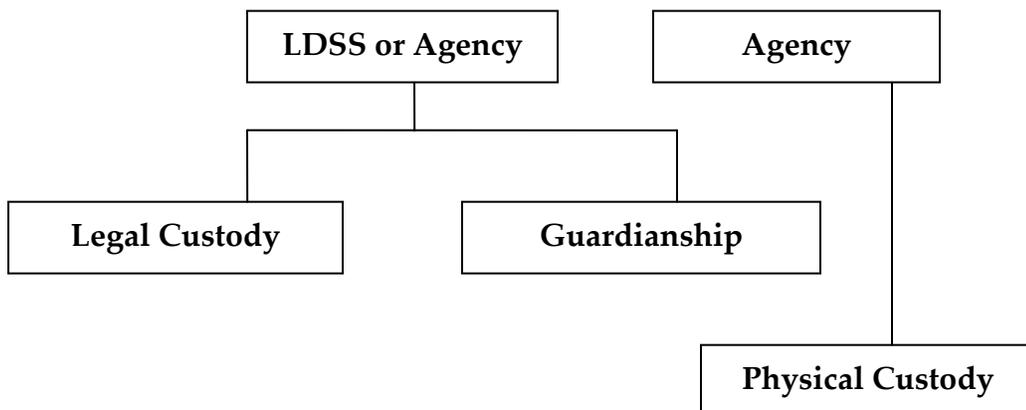
## Child Is In Foster Care

(No surrender or termination, child placed with voluntary agency)



## Parental Rights Surrendered or Terminated

(Child placed with voluntary agency)



## Consent for Routine Medical Services for Children in Foster Care

<b>Placement Authority</b>	<b>Citation</b>	<b>District/Agency Actions</b>	<b>Parental Consent Unavailable</b>
<b>FCA Article 10 (Child Protective)</b>	<b>18 NYCRR 441.22(d) SSL 383-b</b>	<b>Request authorization in writing from the child's parent/guardian within 10 days of entry into foster care</b>	<b>If child has been removed or court-ordered into LDSS custody pursuant to Article 10, Commissioner or designee may provide consent.</b>
<b>FCA Article 7 (Persons In Need of Supervision)</b>	<b>18 NYCRR 441.22(d)</b>	<b>Request authorization in writing from the child's parent/guardian within 10 days of entry into foster care</b>	<b>Seek a court order</b>
<b>FCA Article 3 (Juvenile Delinquents)</b>	<b>18 NYCRR 441.22(d) FCA 355.4</b>	<b>Request authorization in writing from the child's parent/guardian within 10 days of entry into foster care</b>	<b>If the youth is in the custody of the OCFS Commissioner, OCFS Commissioner may provide consent. If the youth is in the custody of the LDSS Commissioner, seek a court order</b>
<b>Juvenile Offenders (OCFS facility)</b>	<b>NY Penal Law 70.20 (4)(b) &amp; (c)</b>	<b>Court asks whether parent/guardian will consent for OCFS to provide routine care</b>	<b>If no consent has been obtained, the commitment order shall be deemed to grant consent</b>
<b>Voluntary Placement</b>	<b>SSL 384-a</b>	<b>Include consent to medical services in the placement agreement signed by the parent/guardian and LDSS</b>	<b>The authorized agency has no authority to consent to medical services. Seek a court order or initiate Article 10 action.</b>
<b>Surrender (both parents)</b>	<b>SSL 383-c SSL 384</b>	<b>LDSS Commissioner or authorized agency to whom the child was surrendered provides written authorization for medical services</b>	<b>Consents signed by the parent/guardian are no longer valid</b>
<b>Termination of Parental Rights (both parents)</b>	<b>SSL 384-b</b>	<b>LDSS Commissioner provides written authorization for medical services</b>	<b>Consents signed by the parent/guardian are no longer valid</b>

## ***REGION IV EXAMPLE***

### **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 [www.ocfs.state.ny.us](http://www.ocfs.state.ny.us) under Resources and Information.

#### **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. (Clarify that additional consent needed each time a psych/beh med is begun or changed.). 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 permitted by NY State regulation to sign consents for PINS and JD youth or children placed in foster care by voluntary agreement.

LDSS is authorized to sign consents for children in foster care who are freed for adoption. LDSS is authorized to sign consents for children placed in foster care due to abuse and neglect.

## ***REGION IV EXAMPLE***

- 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. 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, when a parent refuses or rescinds consent, or when a child/youth is surrendered or freed for adoption.

**REGION IV EXAMPLE**

**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:

\_\_\_\_ names of participants involved  
in the decision-making

\_\_\_\_ list of current medications

\_\_\_\_ results of monitoring current medications  
(including side effects)

\_\_\_\_ current findings  
(i.e. practitioner's status report including  
alternative approaches undertaken)

\_\_\_\_ patient education efforts

\_\_\_\_ 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.*



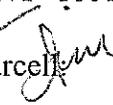
New York State  
Office of  
Children & Family  
Services

George E. Pataki  
Governor

John A. Johnson  
Commissioner

September 12, 2006

Mr. James F. Purcell  
Executive Director  
Council of Family and Child Caring Agencies  
19 West 21<sup>st</sup> Street  
Suite 501  
New York, NY 10010

Dear Mr. Purcell 

I wish to thank you for your letter of August 15, 2006 inquiring into the relationship between Build 18.9, which will include the CONNECTIONS health module, and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

While it is important to maintain a focus on the confidentiality of health information, one must occasionally be reminded that the federal HIPAA Privacy regulations were never intended to impede the flow of protected health information (PHI) when law or regulation requires the disclosure of information. In fact, the creation of barriers that impede this flow of health information is what the federal regulations were created to avoid. The U.S. Department of Health and Human Services (DHHS), in its preamble to the HIPAA Privacy regulations, recognized that "the importance of these required uses or disclosures is evidenced by the legislative or other public process necessary for the government to create a legally binding obligation on a covered entity." See, 65 Fed. Register 82664 (Dec. 28, 2000).

In fact, the federal HIPAA regulations provide - "A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law." See, 45 C.F.R. 164.512(a).

As we approach the December 2006 implementation of Build 18.9, OCFS will be conducting an outreach and implementation effort to assist Local District and Voluntary Agency staff in better understanding how the electronic health record in CONNECTIONS must be used to store health information, including diagnoses and HIV/AIDS information, for certain categories of children in the child welfare system, and how and when this information is permitted to be disclosed by covered entities to the State, service providers, the courts and others, under the federal HIPAA regulations.



In the case of CONNECTIONS, the State is required by both State and federal law to collect information, including health information, on children who are in the foster care system. In the below discussion, OCFS has identified and summarized some of the relevant statutory and regulatory authority for this requirement. In particular, Section 475(1)(c) of the federal Social Security Act (SSA) [42 U.S.C. 675] requires the state to collect case plans that include the most recent information available regarding the health records of the children; and Section 479 of the SSA requires the State to collect and report certain Adoption and Foster Care data elements for all children receiving Title IV-E, including Title XIX (Medicaid) assistance information. See also 45 CFR 1355.40 and 1356.60.

In New York, regulations adopted pursuant to Section 446 of the state Social Services Law require the mandatory use of CONNECTIONS as the state's single statewide automated child welfare system and that the CONNECTIONS system contain, but not be limited to, those data elements required by applicable State and federal statutes and regulations, relating to the provision of child welfare services including foster care, adoption assistance, preventive services, child protective services, adoption services and other family preservation and family support services. § 372 and § 373-a of the Social Services Law, along with state regulations at 18 NYCRR §441.7(a)(1), require every authorized agency to maintain current case records for each child in its care, which must include medical histories of a child placed in foster care (or freed for adoption) and of his or her family. The statutory and regulatory provisions provide that records shall include but are not limited to social, psychiatric and psychological services, and medical and dental reports. See also, 18 NYCRR §441.22(k), which requires each authorized agency to maintain a continuing medical record and dental history for each child in foster care. Therefore, there is clear statutory and regulatory authority for the State to require the collection and storage of this health information in CONNECTIONS.

While neither OCFS nor CONNECTIONS are subject to HIPAA, the health information entered and stored in CONNECTIONS is confidential and is protected by various federal and state laws. In protecting the security and confidentiality of this information, OCFS has constructed a secure health module in CONNECTIONS, which is separate from the remainder of the CONNECTIONS application. Access to this health module is restricted to appropriately assigned case managers, case planners and case workers in Local Districts and Voluntary Agencies assigned to work with the child(ren), and is available only to those staff with a designated Business Function (BF) or case role, which has been assigned based upon statutory and regulatory authority to access this information. Rediscovery of this information by these staff may only be made to those who have been deemed to have a legitimate need to know in accordance with applicable state and federal law.

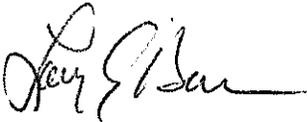
These unique BFs provide specific access, through CONNECTIONS security, and must be assigned by local districts and agencies to designated staff in order to access information in a child's health history folder. Workers who have an assigned role, who have the CONNECTIONS stage on their workload, do not require the additional BF to access health. Only caseworkers that have been designated as responsible for maintaining health information and have been assigned that privilege by the Case Manager or Planner, as

authorized by statute and/or regulation, may access a child's health information. Direct supervisors of designated caseworkers may also access health information for children in their agency.

Finally, the fact that a covered entity is required by law to disclose this PHI to the State by storing it in CONNECTIONS does not subject CONNECTIONS or OCFS to HIPAA, as only those entities that perform specific enumerated transactions are defined as covered entities under HIPAA. Additionally, the disclosure of health information to OCFS would not require OCFS to enter into Business Associate agreements, as Business Associate agreements are only applicable where a third party performs certain functions *on behalf of* a covered entity.

I trust that this information has alleviated concerns regarding the ability of your member agencies to store health information in CONNECTIONS for those children in foster care, without violating HIPAA.

Sincerely,



Larry G. Brown  
Executive Deputy Commissioner

cc: Gail H. Gordon, Deputy Commissioner and General Counsel  
William E. Travis, Jr., Deputy Commissioner  
Jane Lynch, Deputy Commissioner  
Nancy A. Martinez, Deputy Commissioner, Director  
Dianne J. Ewashko

+-----+  
 | ADMINISTRATIVE DIRECTIVE |  
 +-----+

TRANSMITTAL: 97 ADM-15

TO: Commissioners of  
 Social Services  
 Executive Directors of  
 Voluntary Authorized Agencies

DIVISION: Services and  
 Community  
 Development

DATE: July 24, 1997

SUBJECT: Foster Care: Assessment of Foster Children for Capacity to  
 Consent and HIV Risk; Counseling of Adolescents; Legal  
 Consent for HIV Testing; Documentation and Disclosure

SUGGESTED

DISTRIBUTION: Directors of Services  
 Medical Services Staff  
 AIDS Coordinators  
 Staff Development Coordinators  
 Foster Care Supervisors  
 Legal Staff

CONTACT PERSON: BRO - Linda Brown (716) 847-3145 USER ID: 89D421  
 RRO - Linda Kurtz (716) 238-8201 USER ID: 0FH010  
 SRO - Jack Klump (315) 423-1200 USER ID: 89W005  
 ARO - William McLaughlin (518) 432-2751 ID: 0FN010  
 MRO - Fred Levitan (212) 383-1788 USER ID: 72W035

ATTACHMENTS: Listed in Table of Contents where those available on-  
 line are so indicated

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
90 ADM-21 91 ADM-36	94 LCM-64	18 NYCRR Parts 357 428 441 507	SSL 20 34 373-a 398 PHL Article 27-F	Standards of Payment Chap.VIII (B)	



D.	<u>Third Step: Obtaining Legal Consent for Testing</u> .....	15 - 17
	1. Child With Capacity to Consent.....	15
	2. Child Without Capacity to Consent.....	15 - 17
	a. Consent by the parent or legal guardian.....	16 - 17
	b. Consent by the commissioner or designee.....	17
	(1) parental surrender or TPR.....	17
	(2) Article 10 placements.....	17
E.	<u>Fourth Step: HIV Counseling</u> .....	17 - 20
	1. Counseling Required by Public Health Law.....	17 - 19
	2. Counseling Required by Social Services Policy and Regulations.....	19 - 20
F.	<u>Training, Information and Support for Staff and Families Providing Services</u> .....	20 - 21
	1. Information and Training for Staff.....	20
	2. Foster Parent Support and Training.....	20 - 21
IV.	<u>REQUIRED ACTION</u> .....	21 - 32
	A. <u>Designation of Staff Responsible for Assessment</u> .....	21
	B. <u>Required Timeframes for Assessments</u> .....	21 - 22
	C. <u>Basis for Assessment of HIV Risk</u> .....	22 - 23
	D. <u>HIV Risk Factors</u> .....	23 - 24
	E. <u>Obtaining Legal Consent</u> .....	24 - 28
	1. Child Lacks Capacity to Consent and Is Article 10 .....	24 - 25
	2. Child Lacks Capacity to Consent and Is Freed.....	25 - 26
	3. Child Lacks Capacity to Consent and Is Placed Voluntarily or Is JD or PINS.....	26
	4. Child Has Capacity to Consent and Right to Make Decision Re: Testing.....	26 - 28

F. <u>HIV Testing of Child</u> .....	28 - 29
G. <u>Services Required Following HIV Testing</u> .....	29
H. <u>Documentation Required in Uniform Case Record</u> .....	29 - 30
I. <u>Confidentiality and Disclosure of HIV-Related Information</u> .....	30 - 32
1. Persons/Agencies With Direct Access to Information.....	31
2. Persons to Whom Information Must Be Disclosed.....	31
3. Persons Entitled to Information Under Certain Conditions.....	31 - 32
4. Persons With Right to Redisclose.....	32
J. <u>Recruitment of Families to Care for HIV-Infected Children</u> .....	32
V. <u>REPORTING AND SYSTEMS IMPLICATIONS</u> .....	32
VI. <u>ADDITIONAL INFORMATION</u> .....	32
(Appendices A. through M. are attached after VII.)	
VII. <u>EFFECTIVE DATE AND SIGNATURE OF DEPUTY COMMISSIONER</u> .....	33

APPENDICES

- A. Warning Notice Against Redisclosure..(On-line)  
    (Spanish Translation on Reverse)...(On-line)
- B. Model Form: Authorization for Redisclosure of Confidential HIV-Related Information..(On-line)
- C. Model Form: Request for Parental Permission to Test Child Without Capacity to Consent For HIV Infection..(On-line)
- D. Model Form: Decision Regarding Test for HIV Infection by Child With Capacity to Consent..(On-line)
- E. NYS Department of Health Form: Informed Consent to Perform an HIV Test

APPENDICES, Cont.

- F. Hotlines and Information
- G. Anonymous HIV Counseling and Testing
- H. NYS Independent Living Training Network With Information and Resources Available on Adolescent Issues..(On-line)
- I. Adolescent Health Services
- J. HIV Specialized Care Centers
- K. Community Prevention and Primary Care Services
- L. Permanency Planning Service Providers
- M. Legal Services

I. PURPOSE

The purpose of this directive is to provide guidance and set best practice standards for implementing New York State Department of Social Services regulations and policies requiring assessment of risk for human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS) in foster children. Included in this directive are guidelines for determining a foster child's capacity to consent and for obtaining legal consent for HIV testing when risk is identified.

Regulations requiring these actions were adopted and effective on August 23, 1995, amending sections 428.3, 441.22, and 507.2 of Title 18 NYCRR. New York State statutes related to these regulations include Public Health Law, Article 27-F, which establishes criteria for HIV-related testing and confidentiality; Section 373-a of the Social Services Law (SSL) which specifies the persons and entities to whom the medical history of the foster child must be provided; and Section 398(6) of the SSL, which requires local commissioners of social services to provide for expert mental and physical examinations of any foster child reasonably suspected of having a mental or physical disability or disease and to provide necessary medical or surgical care for any child needing such care. In addition, standards of care and treatment applying to residential programs for children must be provided according to SSL, Section 462.

II. BACKGROUND

As the number of HIV/AIDS infection and mortality cases continues to increase nationwide, the number of New York families and children infected and affected by the epidemic also continues to rise. While the highest statistics are reported by New York City, no area of the state is exempt from mounting numbers of cases of HIV infection. No vaccine and no cure for the disease has been developed as of the issuance of this directive. However, continuing research has resulted in development of new treatments and medications being used by the medical community to prolong life and maintain the quality of life for those infected. More effective early treatment makes the identification of children at risk more urgent and has resulted in the determination of the State Department of Social Services to develop this major policy initiative for the benefit of the children in foster care. The regulations emphasize the importance of preventive measures, counseling and education of youth and risk reduction, as well as testing when risk is identified, and medical care as needed.

The 1995 regulations were an important addition to previous requirements set forth in the Department's earlier Administrative Directive (91 ADM-36) issued September 16, 1991: "Foster Care and Adoption: HIV-Related Issues and Responsibilities." That directive focused on confidentiality and disclosure issues, documentation, and required training and information for staff involved in HIV-related issues, HIV counseling and testing.

The addition of the HIV assessment, counseling and testing regulatory requirements discussed in this directive continues the Department's efforts to address a health care crisis affecting families and children of all ages, with particular focus on children in foster care.

Chapter 220 of the Laws of 1996, which became effective February 1, 1997, required that all infants born in hospitals or birthing centers be tested for HIV. No parental consent for this additional component of the prior existing Newborn Screening Program is required. For a discussion of the significance of this testing in relation to an authorized agency's responsibilities, see page 10 of this directive.

III. PROGRAM IMPLICATIONS

The regulatory requirement for assessment of HIV risk for each child placed in foster care, regardless of age, provides a higher standard of awareness and medical services related to the HIV epidemic affecting children and families in New York. Practice and program implications of this mandate will include development of new agency procedures for designation of informed staff to conduct assessments, obtain legal consents, arrange for HIV testing, provide follow-up services and ongoing counseling.

A. DESIGNATION OF STAFF TO MAKE ASSESSMENTS

Designation of staff to make the assessments of capacity to consent and HIV risk is an important internal administrative decision for each authorized agency. Such designations must include serious consideration of staff information and training on HIV/AIDS issues as required by Department regulations, as well as staff experience with particular age groups. Counseling and the ability to discuss prevention and risk reduction are skills needed by designated staff working with older children. When medical staff or a clinical social worker is available within the agency, such persons may be able to undertake the assessments with a minimum of additional preparation and training. Designated staff will need to use flexibility, cultural sensitivity, and their own experience and judgment in implementing assessment procedures, and modify those procedures based on the age, developmental stage and cognitive abilities of the foster child.

Staff designated to make the assessments should take advantage of further training opportunities offered through Department contractors, or through other agency, community or medical training providers, as discussed on page 20 of this directive. (Please also see pages 24 and 25 of 91 ADM-36 for agency requirements to provide HIV-related information and training for staff initially and annually.)

In addition to understanding the basic medical/physical development and impact of the disease, designated staff making the assessments of capacity to consent and HIV risk will need to learn the legal standard for capacity to consent as defined on page 5, as well as the rules regarding HIV-related confidentiality and the penalties for breaking such rules (see page 30 and Appendix A). The ability to relate to children in different stages of development and growth will be important in making the assessments, requiring sensitivity to the developmental and emotional status of each child. Ability to counsel adolescents will be a particularly important skill needed by staff designated to work with this age group.

B. FIRST STEP IN ASSESSMENT: DETERMINATION OF CAPACITY TO CONSENT

Determination of the foster child's capacity to consent is the first step for designated staff to take in meeting the requirements for assessment of HIV risk. No HIV testing, even after identification of risk, may take place unless written consent has been given by a person authorized to give consent according to Public Health Law, Article 27-F. A person with capacity to consent is the only person who may provide the required written informed consent before HIV testing may take place. For a child without such capacity, written consent for HIV testing must be obtained from a person authorized by law to give such consent (see pages 15-17 of this release).

An assessment of a child's capacity to consent is required by Department regulations within five business days of each child's entry into foster care. For each child who entered foster care prior to September 1, 1995, an assessment of capacity to consent was to have been made 60 days prior to the child's next medical examination or to the next service plan review occurring after August 23, 1995, whichever was earlier.

1. Alternatives and definitions

Staff designated to determine the child's capacity to consent are required to consider in their initial five day assessment which of the following two alternatives applies to the child: (1) there is NO POSSIBILITY that the child has the capacity to consent, or (2) there may be A POSSIBILITY that the child has the capacity to consent. In the case of the second category, staff have 30 days to make a final determination regarding the child's capacity to consent. The determination regarding which

category applies to the child must be made without specific regard to the child's age, and the decision must be based on the definition of capacity to consent provided in Article 27 F of the Public Health Law and included in Department regulations at section 441.22 (b)(1) as follows:

+++++

CAPACITY TO CONSENT

Capacity to consent means an individual's ability, determined without regard to the individual's age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure, or of a proposed disclosure of confidential HIV-related information, as the case may be, and to make an informed decision concerning the service, treatment, procedure or disclosure.

+++++

Decisions regarding capacity to consent are to be made on a case-by-case basis, with consideration given to the developmental stage and cognitive abilities of the child.

"Cognitive abilities" refers to a child's level of perception, memory, judgment, and understanding as these characteristics relate to HIV risk factors, risk behavior reduction, HIV testing, counseling on the nature and consequences of the disease, and the disclosure of HIV-related testing information.

In cases where a designated staff person has difficulty making a satisfactory determination regarding an individual child's capacity to consent, supervisory assistance is recommended. In rare instances when the decision is not resolved with supervisory assistance, consultation with a third professional may be necessary.

2. Assessment Categories

While the definition of capacity to consent prohibits determination based on specific age, the application of the definition to children in foster care requires an assessment based on realistic levels of development and cognitive abilities. The following assessment categories provide best practice guidelines for making the determination:

a. Infants and pre-school children

Infants and pre-school children entering foster care would clearly have NO possibility of capacity to consent, based on the legal definition given above. In such cases,

designated staff are to proceed immediately with the assessment of risk for HIV infection described in Section III. C. beginning on page 7. For those children with NO possibility of capacity to consent, the HIV risk assessment, based on medical or psychosocial information available at the time, must also be completed within the first five business days of entry into care. Children in this category who entered foster care prior to September 1, 1995 were to have an assessment of capacity to consent and HIV risk 60 days prior to their next periodic medical examination or service plan review, whichever came earlier.

In cases where an infant or pre-school child has already been tested through the Department of Health mandated universal newborn testing program effective February 1, 1997, and the results of such test are made available to the authorized agency, documentation of any known risk and results of the HIV testing at birth are to be included in the child's uniform case record. This information will need to be shared with the child's medical provider at the time of the comprehensive physical examination required within 30 days of the child's entry into foster care.

b. Elementary school children

A foster child in this category would generally have NO possibility of capacity to consent, particularly if the child is in the lower elementary grades. It is unlikely that a child under the age of puberty would be fully able to understand and appreciate the nature of this complex disease or to make an informed decision regarding testing and disclosure. Only in exceptional cases might such a child be considered to have A possibility of capacity to consent. (The fact that a child is assessed to have no capacity to consent does not eliminate consideration of informing and counseling an elementary school child regarding prevention and risk reduction at a level appropriate for the age and development of the child.)

Further, since capacity to consent is to be determined on a case-by-case basis, if there may be A possibility of such capacity, staff may take up to 30 days after the child's entry into care to make a firm decision and to complete the HIV risk assessment. For elementary school children who entered foster care prior to September 1, 1995, determination of capacity to consent and assessment of risk for HIV infection were required no later than 60 days before the child's next periodic medical examination or service plan review, whichever came earlier.

c. Pre-adolescent, early adolescent middle school children

Foster children attending middle school or junior high school are more likely to have the capacity to consent

based on the legal definition. However, the broad range in individual physical, mental and emotional development in children at this stage of growth requires a case-by-case determination of such capacity within the 30 day timeframe allowed by the regulations when there may be A possibility of capacity to consent. In this developmental stage, supervisory review of the determination of capacity is suggested, and where a question remains, consultation with a third party may be necessary.

d. High school and post-high school youth

Young people in these categories will generally have the capacity to consent to HIV testing and disclosure, although there may be exceptions in cases of developmental delay or disability and/or mental or emotional instability. In most cases, through the required information and counseling process within the 30 day timeframe for determination of capacity and assessment of risk, adolescents and young adults will be able to understand and appreciate the nature and consequences of the disease and to make an informed decision regarding the recommended testing when risk is identified.

Unresolved questions regarding capacity to consent in this stage of development should be referred to a supervisor and may suggest the need for consultation with other appropriate professional staff, such as a psychologist or clinical social worker.

When a youth in foster care is determined by staff on the basis of developmental stage and cognitive abilities to have the capacity to consent, that young person has the right to make his or her own decision on whether to be tested for HIV infection.

C. SECOND STEP: RISK ASSESSMENT FOR HIV INFECTION

1. Required timeframes for HIV risk assessment

The second step in the requirements for HIV assessment and testing involving children in foster care is the determination of HIV risk factors in the child's medical and psychosocial history, based on the information available. For children with NO possibility of capacity to consent, the assessment of HIV risk must be completed within the first five business days of entry into care. If agency staff determine that a child may have A possibility of capacity to consent, the timeframe for both the determination of capacity to consent and the HIV risk assessment is extended to 30 days from entry into care.

For each child who entered foster care prior to September 1, 1995, determination of capacity to consent and assessment of HIV risk were to be completed 60 days prior to the child's next

service plan review or next scheduled medical examination, whichever came earlier.

## 2. HIV risk factors

Three groups of HIV risk factors for use during the assessment process are provided in the Department's regulations (section 441.22(b) of 18 NYCRR) and in Section IV.D. (pages 23-24) of this directive. Developed with the cooperation of the medical community and the AIDS Institute of the Department of Health, the listed factors are to be used by designated staff in reviewing the health/medical and psychosocial history and other written records regarding the child, as well as for guidance in discussions as appropriate with a child, youth or child's parents. The risk factors should never be used as an oral checklist with children, but are intended primarily for internal use by staff in making the assessments.

The first group of risk factors is relevant for an assessment of infants and pre-school children, with the factors related to perinatal transmission from the mother to the infant during pregnancy, at birth or through breast-feeding. The second group, a list of family psychosocial/health factors which also may result in perinatal HIV transmission, is primarily related to infants and pre-school children, but has been identified as a latent source of transmission to some elementary and middle school children as well.

The third group provides a list of factors primarily used for assessment of older children, based on the child's behavior and/or other means of direct transmission. (See further discussion on pages 23-24.) It is this third group which may be helpful in counseling and discussions on prevention and risk reduction with older youth who may be able to understand the serious issues involved in transmission of HIV/AIDS.

## 3. Assessment of HIV risk through written records

For all age groups, the health/medical and psychosocial family history of the child, to the extent available, is the foundation for the assessment of HIV risk. Therefore, a review of any written information/records concerning the child is essential. Information regarding the child or child's family may be available through the following:

- a. any medical or psychosocial records available at the time of placement or that become available at any time while the child is in foster care;
- b. any relevant information recorded as a result of contacts and discussions with the child's family, foster family, or medical providers;

c. child protective services investigative reports on the Preliminary Assessment of Safety form (DSS 4337) or other written record.

When a child is identified through such available information as having one or more of the HIV risk factors listed on pages 23 and 24 of this directive, the risk factor(s) and basis for the determination are to be documented in the uniform case record of the child. Authorized agencies must keep all HIV-related information in the medical history file of the child which is technically part of the uniform case record, but is often kept in a separate location in order to limit access to specified persons.

When a review of the information available is insufficient to determine whether a child is at risk, staff will need to make a reassessment when new information becomes available. In all cases, staff will need to review any additional relevant information at each service plan review and each periodic medical examination of a child that occurs after the initial assessment of the child pursuant to Section 441.22(b)(6) of Department regulations.

#### 4. Assessment of HIV risk indicating direct, person-to-person discussion/contact

The following guidelines for assessment of HIV risk involving person-to-person contacts, discussion and counseling, as appropriate, are provided in the same four categories as those used above to determine capacity to consent:

##### a. Infants and pre-school children

Available written records of the child in this category will generally be sufficient to make an assessment of HIV risk. However, if relevant information is lacking, designated staff may wish to make reasonable efforts to contact the parents of the child, other staff, medical or community services providers who are known to have knowledge of the child and/or the child's family.

It is this category of child for whom early intervention and medical treatment have been determined through scientific studies to be extremely important in maintaining the quality of life and prolonging life. The identification and medical care of infants and pre-school children who may be HIV-infected are therefore urgent goals of the Department's assessment and testing policy and regulations. If one or more risk factors are identified for a child in this category, immediate efforts should be

made to obtain necessary legal consent for testing or re-testing as necessary and to arrange for the test so that early treatment and services may be provided if the child tests positive.

+++++

Virtually all children born in the State since February 1, 1997 are tested for HIV antibodies shortly after birth as part of the State's Newborn Screening Program (NSP). The authorized agency should not retest a child under the age of twelve months unless the child tests negative at birth but there are risk factors that are present after birth (i.e., the infant has been breast fed); the authorized agency is unable to obtain the NSP test results; or the child's NSP test was positive necessitating follow-up PCR or viral culture testing discussed below. Additionally, given the availability of the test results, as described below, authorized agencies should seek the test results for all foster children born on or after 2/1/97, up to the age of 12 months, regardless of whether or not there are risk factors present. The test results should be available approximately ten days after the child's birth.

There are two possible methods for obtaining the test results, both of which require obtaining one of the following identifiers: a) the Newborn Screening Program Blood Collection form identification number (available from the birth hospital through the Newborn Screening Designee; however, after a couple weeks following birth may only be available through the hospital's medical records office which, depending upon the hospital, may take too long a period to be made available to be viable); or b) the mother's social security number.

A physician caring for the foster child can access the newborn test results through the NSP's Voice Response System (VRS) at Wadsworth Laboratory, using one of the two identifiers described above. (Note: All physicians must register with the NSP at (518) 473-7552 if they have not used the system before.) If the authorized agency does not find this method of obtaining the test results practicable for a particular child, the agency can instead contact the ACS Pediatric AIDS Unit (212) 266-3304, if the child is in ACS' custody, or Carol Shortsleeves from this Department at (518) 474-9594. If you choose to use the ACS or NYSDSS contact person, it will still be necessary to have one of the two identifiers listed in the preceding paragraph. The ACS and NYSDSS will then contact the State Department of Health (SDOH) Laboratory to obtain the test result. (SDOH will be evaluating the volume of requests it receives for test results from ACS and NYSDSS to determine its ongoing

capacity to provide results for foster children up to the age of 12 months.)

The newborn's antibody test results reflect the HIV status of the mother. A negative result means the mother and newborn are most likely not infected. A positive result means the mother is infected and the newborn may or may not be infected. To determine if the newborn is infected, a child must be retested using a more sophisticated "PCR" test (or viral culture). All infants will need at least two PCR tests. The optimal time for the first PCR is at the first pediatric visit or by one month of age. HIV infection can be reasonably ruled out for infants who have had two negative PCR tests after one month of age, with one test coming after 4-6 months of age. (The SDOH does HIV PCR testing on all HIV positive infants less than 18 months of age for free.) The SDOH requires the birth hospital to notify the physician responsible for the baby's care of the antibody test results. If the result is positive, the physician must administer the follow-up PCR test(s) and provide or arrange for post-test counseling for the infant's mother. Any PCR test required to be administered to an HIV-antibody positive infant up to the age of 12 months born on or after 2/1/97 does not require the obtaining of legal consent.

The SDOH requires birth hospitals to ensure that an infant who tests HIV-antibody positive on the Newborn Screening test is located and has a definitive diagnosis by PCR (or viral culture). The hospital is also required to obtain the results of the PCR test (or viral culture). It is important to determine those infants who are infected so they can receive early care, including drugs to prevent PCP (a serious form of pneumonia to which very young HIV-infected infants are particularly susceptible).

There may be occasions when a child tests HIV-antibody positive, enters foster care shortly after birth, and the birth hospital (or the SDOH, if the hospital asks for assistance) is trying to locate either or both the infant and the mother. In relation to the infant, the authorized agency should provide the following information, upon request, to the birth hospital or the SDOH:

- (1) the location of the infant;
- (2) the name and phone number of the physician/clinic caring for the infant;
- (3) whether a PCR (or viral culture) is scheduled for the infant or has been done; and
- (4) the results of such testing.

If the birth hospital or the SDOH asks for assistance in locating the infant's mother, it is for the purpose of informing her of the test result, providing counseling, and

encouraging her to receive appropriate medical care, especially if she was previously unaware of her HIV positive status. If the case planner knows the whereabouts of the infant's mother or is in contact with her, he/she should tell the infant's mother that they have been asked to inform her that she should contact the birth hospital to obtain important medical information about herself. After making such contact as soon as practicable, the case planner should inform the entity trying to locate the infant's mother that the message was conveyed.

+++++

b. Elementary school children

Written records and reports should serve as the foundation for the assessment of HIV risk in this category of children. Relevant risk factors will be found primarily in the first two groups of factors listed on pages 23 and 24, involving perinatal transmission of HIV.

However, staff should be aware that some items in the third group (e.g., sexual abuse), may also be applicable to elementary school (and pre-school) children. After checking the written records available, a designated staff person with experience and ability in relating to this category of children may wish to initiate a discussion with the child as appropriate about HIV risk behavior and the reasons for the assessment and possible testing.

The approach used in such discussions will depend on the developmental and emotional status of the child and the ability of the child to understand such explanations. For example, a child may be among those children who have already been involved in substance abuse or in sexual activity. If there is any indication of such risk behavior, and if the child appears able to engage in a discussion of prevention issues, the staff should begin such a discussion and provide opportunities to continue on other occasions.

In many cases in this category, designated staff may be able to discuss with the child who has one or more risk factors the importance of the HIV test in order to provide any necessary medical care. It should be explained to the child that the test will probably involve drawing blood, but will be no more painful than, for example, the types of required injections the child has experienced to protect against disease -- the required pre-school vaccinations.

While the older child in this category may be determined to have capacity to consent as defined in section III.C., most of these children will probably not meet the standard. Therefore, if one or more HIV risk factors are identified, and the child is determined not to have the capacity to

consent, staff will need to obtain the necessary legal consent for HIV testing from someone other than the child and arrange for the test according to procedures described in paragraph III.D. below.

c. Pre-adolescent, early adolescent middle school children

Many children in this category may meet the standards of development and cognitive ability leading to a determination of capacity to consent. HIV risk assessments involving children at this level should be made by staff who are well-informed regarding HIV/AIDS issues and have training and experience in working with children in this category.

While a review of written records will again serve as the basis for an initial assessment of risk, staff must initiate a person-to-person discussion with each youth within the first 30 days of entry into foster care in order to complete a determination of capacity to consent and a valid assessment of HIV risk.

Staff should take care to ensure that the initial and subsequent meetings of staff with the child regarding HIV risk be non-confrontational and non-threatening. Again, the risk factors listed in Section IV. D. of this directive should not be used as an oral checklist in assessment and counseling meetings with children and youth. The list is intended as a guide for staff in reviewing records and discussing prevention, risk reduction, and transmission of the disease with children and youth as appropriate for their level of understanding.

Risk factors particularly relevant to this category of child will be those in the third group on page 24 related to direct transmission of HIV through personal contact involving blood or semen, although perinatal transmission has been documented as the risk factor in some cases. Discussion of the third group of factors can form the basis for providing important information and counseling to the child. The initial meeting will be important in helping the child understand the reasons for the required assessment of HIV risk in order to offer support services and medical care if needed. Continuing opportunities for sharing information should be offered. If risk is identified, other issues for discussion will include required information on confidentiality and disclosure as discussed on page 30 of this directive.

d. High school and post-high school youth

As with the middle school category above, the initial meeting with high school youth will be important in helping the youth understand that the required HIV risk assessment

and discussion are meant to offer opportunities for sharing information on prevention and reduction of risk behavior, as well as to provide a recommendation for testing if risk is identified.

As is true for the pre-adolescent children, staff working with this category of youth will need to be sensitive and flexible in providing opportunities for such counseling and discussion and to understand that the young person may be both emotionally and physically exhausted by the events which have led to placement in foster care. At no time should such meetings become threatening, confrontational, or coercive.

The risk factors particularly relevant to high school and post-high school youth are those on page 24 related to direct transmission of HIV from another person, generally through the youth's own behavior, particularly related to sexual activity or drug abuse. Other possible risk factors are sexual abuse and, very rarely today, contaminated blood transfusions. Prior to discussions and counseling sessions with the youth, staff will need to review any information available through CPS, medical history, or other documentation related to possible HIV risk.

If the youth has the capacity to consent and is identified through the HIV risk assessment as having one or more risk factors, staff will recommend testing and discuss with the youth the reasons why such a test is important in order to obtain medical and other services if the result is positive. In addition to a discussion of the identified risk and the recommendation for testing, staff will need to forthrightly discuss the issues of confidentiality and disclosure as they apply to foster children (see page 30), as well as explaining to the youth the two types of testing available -- confidential and anonymous -- and the differences between the two. The youth with capacity to consent then has the absolute right to make his or her own decision regarding whether to undergo HIV testing and, if so, the type of testing.

In confidential testing of children in foster care, the name of the child and the authorized social services agency with responsibility for the child are recorded by the test site, and the results of the test are to be provided to the agency, as well as to others specifically permitted by law to be given such information as discussed on pages 30-32.

Anonymous testing is available in certain locations only to persons with capacity to consent. The person tested is identified only by an ID number. Results of the test can be given only to that person, regardless of foster care

status. However, a recent Department of Health policy change allows the person who chooses the anonymous type of testing to request a conversion from anonymous to confidential status at the time the results are provided. This makes possible the transmission of the results to a medical or social services provider in order to obtain needed treatment or services.

As in all categories, documentation in the case record will be necessary on the assessment of capacity to consent, assessment of HIV risk, counseling provided, and in the case of youth with capacity to consent, the decision regarding testing and arrangements made for the test if consent is obtained.

D. THIRD STEP: OBTAINING LEGAL CONSENT FOR TESTING

When HIV risk has been identified, designated staff will need to obtain legal written consent from an individual with legal authority to consent before the child can be tested.

1. Child with capacity to consent

As indicated on the preceding page, the child or youth who has been determined to have capacity to consent is the only person who can make a decision regarding testing and provide legal written consent for his or her HIV test.

If the youth agrees to be tested, he or she will be asked to sign a brief dated statement of consent (see model form in Appendix D) to be retained in the case file. (Please note that this brief statement is for the social services agency record; at the testing site, the youth will be asked to sign the Department of Health official informed consent form (see Appendix E for official form).) Staff will then proceed to make arrangements for the test within the next 30 days.

2. Child without capacity to consent

When a foster child does not have capacity to consent, there are three possible sources, all with specific limitations, for the necessary legal consent for the HIV testing of the child:

0 - the parent or legal guardian of the child; or

0 - the local social services commissioner or designated representative on an administrative level; or

0 - a court order in cases of urgent medical necessity as defined on page 16-17.

+++++

FOSTER PARENTS OR PROSPECTIVE ADOPTIVE PARENTS MAY NEVER PROVIDE LEGAL CONSENT FOR TESTING OF A FOSTER CHILD. CASEWORKERS MAY NEVER PROVIDE LEGAL CONSENT FOR TESTING OF A FOSTER CHILD.

+++++

a. Consent by the parent or legal guardian of the child

(1) When HIV risk has been identified for a child without capacity to consent, and the child has been taken into custody under Article 10 as an abused or maltreated child, or has been taken into or kept in protective custody or removed from the place where the child was residing pursuant to section 417 of the SSL or section 1022, 1024, or 1027 of the FCA, it is necessary to discuss with the parent or guardian the child's risk and the need for testing. Staff need to ask the parent/guardian for permission to test the child and to ask for a written response within 10 days of the request. If the parent agrees to provide legal consent for the test and is able to be present at the test site with the child to sign the required Department of Health pre-test consent form, staff should schedule the appointment and make other arrangements, including transportation as necessary.

If the parent refuses or is unable to provide written permission for testing the child identified as being at risk for HIV after reasonable efforts have been made to contact and discuss the importance of testing, it will be the responsibility of the commissioner or designated representative to provide the legal consent for testing in Article 10 cases.

(2) When HIV risk has been identified for a child without capacity to consent, and the child has been placed in foster care voluntarily by the parent/guardian, or has been placed in foster care as a Person in Need of Supervision (PINS) or as a Juvenile Delinquent (JD), written parental consent is required in order to test the child. If the parent refuses to provide such consent, staff are encouraged to meet with the parent to discuss the importance of early treatment and care for children who may be HIV-infected. If the parent continues to refuse, the authorized agency's only alternative in such cases is to determine whether to ask for a court order, pursuant to FCA 233, based on urgent medical necessity as defined below.

+++++

Urgent medical necessity, for the purpose of this directive, means a determination that:

- (1) a child entering care has previously tested positive and/or has symptoms related to HIV infection requiring immediate medical attention; or
- (2) the infant or pre-school child has been abandoned; or
- (3) the child's parent has HIV/AIDS or has died from HIV/ AIDS.

+++++

b. Consent by the local social services commissioner or designated representative.

+++++

"Designated representative" refers to designation by the local social services commissioner of specific staff on an administrative level within the agency or in a contract agency to provide written consent on behalf of the commissioner in appropriate cases; for example, a deputy commissioner, director of services, or the executive director of a voluntary child caring agency.

+++++

(1) When HIV risk has been identified for a child without capacity to consent, and the parents of the child have surrendered guardianship and custody of the child or parental rights have been terminated, the local social services commissioner or designated representative must provide the necessary written consent for testing the child. Designated staff will need to obtain the signed consent and make arrangements for the test.

(2) When HIV risk has been identified for a child without capacity to consent, and the child has been taken into or kept in protective custody pursuant to Article 10 of the FCA or section 417 of the SSL, and the parents are unavailable or have refused to provide consent for the child to be tested, the local social services commissioner or designated representative will provide the necessary written consent, as explained in a. above.

E. FOURTH STEP: HIV COUNSELING

1. Counseling required by Public Health Law

Article 27-F of the Public Health Law requires that the person who provides written consent for the HIV test must receive pre- and post-test counseling and information regarding the test at the test site. This rule is applicable to the child with capacity to consent and to the parent or guardian who accompanies the child without capacity to consent to the test site.

However, such a rule would not be applicable to a physician who provides consent in an emergency situation, nor to the social services commissioner with custody of the child, nor to the commissioner's designated representative with the legal right to sign the required consent form prior to an HIV test for foster children without capacity to consent. Again, caseworkers or foster parents who accompany a child to a test site may not sign consent for the child's testing, but should carry with them the required consent form signed by the appropriate person. They may be asked by site personnel to receive such pre- and post-test counseling as is appropriate.

Counseling and information provided at the test site are governed by the requirements of the New York State Department of Health, and will include an overview of the following as appropriate for the child to be tested and/or the adults present:

- a. the HIV test, including its purpose, the meaning of the results, and the benefits of early diagnosis and medical intervention;
- b. the procedures to be followed, including that the test is voluntary for persons with capacity to consent; that consent may be withdrawn at any time by a person with capacity to consent; and that anonymous testing is available for persons with capacity to consent;
- c. the persons entitled to disclosure of HIV-related information according to Public Health Law;

+++++

(Please note that this information may be confusing unless the foster child, parent or guardian, foster parent, or caseworker present at the testing site has been previously informed regarding confidentiality and disclosure issues under Social Services Law and regulations, which differ from and add to the basic requirements in Public Health Law.)

+++++

- d. the nature of AIDS and HIV-related illness, information about discrimination problems and the legal protections against such discrimination, and information about risk behavior for transmission/contraction of HIV infection;
- e. referral to an anonymous testing site upon request of a child with capacity to consent.

These Public Health Law requirements in no way replace the responsibility for authorized agencies providing foster care to

meet the assessment and counseling requirements set forth in Department regulations and this directive.

## 2. Counseling required by social services policy and regulations

Social services agency staff need to ensure that foster children and youth, parents or legal guardian, foster and prospective adoptive parents, as applicable, are prepared and informed prior to the child's testing site visit. When the test is conducted in-house, qualified and licensed medical employees of the authorized agency may be designated by the administration to provide the information and counseling needed to meet both Public Health Law and social services requirements. However, if the testing site is external to the agency, the staff there will provide standard information as required, but may have no familiarity with the child's background or medical history and no reason to develop a continuing relationship with the child. Therefore, the PHL counseling procedure will not negate the foster care agency's responsibility to maintain a counseling relationship with the child, especially with adolescents.

One of the most difficult and critical challenges of the HIV assessment and testing policy is the need for staff to provide information and counseling to pre-adolescent and adolescent foster youth on HIV prevention and risk reduction as required by section 441.22(b)(4)(i)(h) of Department regulations and this directive. Department-contracted training for staff on "Adolescents and AIDS" is available to prepare staff for this responsibility, as are a variety of materials from the Department of Health and community organizations. Any combination of individual and group discussions, booklets, pamphlets and other print materials, videos, peer support groups, peer theater productions or other means of communication, as well as directed counseling, may be useful in gaining the young person's attention regarding the importance of HIV prevention and risk reduction. Medical centers and youth-serving organizations in urban areas are often resources for this essential service.

In all cases, the youth with capacity to consent must be informed by designated staff of any risk factors identified for him or her, and the importance of being tested in order to receive medical care and services if HIV-infected. In addition to being offered the choice of confidential or anonymous testing as described on pages 14 and 15, the youth should be fully informed as to the confidentiality and disclosure rules required by Social Services Law; for example, the requirement that agencies inform the child's foster or prospective adoptive parents of all known medical issues, including HIV-related information concerning the child, as discussed on pages 31 and 32.

Along with discussion of the risk assessment and information regarding an HIV test, designated staff working with children

who have any possibility of capacity to consent should ensure that they have ongoing opportunities for access to further information and discussion.

F. TRAINING, INFORMATION AND SUPPORT FOR STAFF AND FAMILIES PROVIDING SERVICES RELATED TO HIV ASSESSMENT, TESTING AND CARE OF AT RISK FOSTER CHILDREN

Every authorized agency will need to develop a plan to provide or arrange for the training, information and support necessary for all persons involved in the HIV-related assessment, testing and care of at risk foster children.

1. Information and training for staff

All staff who are given access to confidential HIV-related information will need information and training within 45 days of employment on basic medical, legal and service issues related to the HIV risk assessment and testing of foster and adoptive children. In addition, annual updates on such issues will ensure that information is provided on continuing changes in medical care and legal procedures. Such information may be provided through any combination of formal training, informal discussion and informative materials, so long as all topics required by Section 431.7(c) of Department regulations are covered.

Basic and advanced AIDS training for agency staff is provided by the Department under contract with qualified organizations. In addition, other state agencies, including the Department of Health, as well as many urban medical centers and community service providers, offer conferences, forums, and classes related to HIV/AIDS issues.

+++++

Please refer to Administrative Directive 91 ADM-36, "Foster Care and Adoption: HIV-Related Issues and Responsibilities," pages 16, 24-25 for more detailed discussion of training issues. For additional resources, see Appendices attached to this directive for possible contacts, consult your agency's staff development coordinator, or contact your Regional Office for further information on available training.

+++++

Some agencies working with HIV-affected children and families have found that support groups for staff have been effective in helping them cope with the emotional stress involved in providing services to this population. In many communities, networks of HIV/AIDS service providers offer mutual support activities. Appendices attached to this directive suggest contacts.

2. Foster parent support and training

Foster parents caring for HIV-infected children should also be

encouraged to take advantage of any educational opportunities provided by the agency or through the wider community to develop greater understanding of this complex disease and the skills necessary to support such children. Basic and advanced AIDS training for foster parents is provided by Department contractors.

If the child is designated as a "special" case, the foster parents must meet an annual training requirement of four hours in order to receive an enhanced (special) maintenance payment. If the child is designated as an "exceptional" case requiring a high level of care, foster parents must meet an annual training requirement of five hours in order to receive an exceptional maintenance payment. (See section 427.6 of Department regulations or the Standards of Payment Manual, Chapter VIII (B).)

#### IV. REQUIRED ACTION

Authorized agencies are required to take the following actions related to HIV risk assessment of all foster children and to HIV testing when appropriate:

##### A. DESIGNATION OF STAFF RESPONSIBLE FOR ASSESSMENTS OF CAPACITY TO CONSENT AND RISK OF HIV INFECTION

1. Each authorized agency must designate staff with appropriate background, training and experience to make the required assessment of each foster child's capacity to consent and risk of HIV infection. Such staff persons may be caseworkers, supervisors, clinical social workers, or medical personnel.

2. Qualifications of staff designated to make HIV risk assessments must include:

- a. participation in HIV-related training; or
- b. knowledge of HIV confidentiality requirements.

##### B. REQUIRED TIMEFRAMES FOR ASSESSMENTS OF CAPACITY TO CONSENT AND HIV RISK

1. Within five days of entering foster care, each child, regardless of age, must be assessed for capacity to consent as defined in Public Health Law and on page 5 of this directive.

A determination must be made and documented by designated staff within each authorized agency as to whether there is no possibility that the child has the capacity to consent or whether it is possible that the child may have the capacity to consent to HIV-related testing.

2. If a child is determined to have no possibility of capacity to consent, an assessment of risk for HIV infection must also be

determined within the first five days of entering care and documented as described beginning on page 7.

3. If it is determined that it is possible that a child may have the capacity to consent, an informed decision must be made and documented within 30 days of the child's entry into care regarding such capacity, and an assessment of risk for HIV infection must also be determined within the 30 day timeframe as described beginning on page 7.

4. For children entering care prior to September 1, 1995, all such children were required to be assessed for capacity to consent and risk of HIV infection at least 60 business days prior to the children's next scheduled periodic medical examination, as indicated in section 421.22 of Department regulations, or at least 60 business days prior to the children's next required service plan review, whichever occurred first.

C. BASIS FOR ASSESSMENT OF HIV RISK

1. For the child determined within five days of entry into foster care to have no capacity to consent, the child must, within the same five day period, immediately be assessed for risk of HIV infection based on the available medical and psychosocial history of the child, whether documented in a Child Protective Services (CPS) report, preventive services or other records, or provided orally by the child, parent, caseworker, or medical provider.

2. When it is determined within five days of entry into care that a child may have capacity to consent, such determination of capacity to consent must be made within 30 days. The child also must be assessed for risk of HIV infection within that 30 day timeframe, using available medical and psychosocial history of the child as documented in reports and records, and through oral discussions with the child or medical provider as appropriate.

Oral assessments and counseling of the child must be conducted as appropriate for the age and development of the child, as discussed in Section III of this directive. Such discussions with the child must never be confrontational or threatening in any way. The second group of risk factors involving family members should not be used as an oral checklist with a child.

3. Assessments must be based on the risk factors listed on pages 23 and 24.

4. Results of the assessment must be documented in the child's medical record section of the uniform case record, with any risk factors identified. If no risk factors are identified, documentation in the uniform case record must specify that an assessment has been completed as required and must record the

date of the assessment. If the risk assessment for infants or very young children cannot be completed within required timeframes because of an emergency placement with no medical or social history of the child available, dated documentation in the case record must state that fact, along with a plan for obtaining such history. However, please note in the risk factors in section IV. D that abandonment is a valid risk factor, and also, as stated in C.1 above, a review of a CPS report or preventive services record may establish risk.

#### D. HIV RISK FACTORS

There are three groups of risk factors that must be used as the basis for determining whether the foster child or youth is at risk for HIV infection. The first two groups are primarily applicable to infants or young children who may have been infected at birth. The third group is primarily applicable based on the personal behavior of older children and adolescents, although there are important exceptions, such as sexual abuse. These risk factors include:

1. Risk factors associated with direct perinatal transmission of HIV infection from the mother during pregnancy, at birth, or through breast-feeding:
  - a. the child had a positive drug toxicology or drug withdrawal at birth;
  - b. the child had a positive test for syphilis at birth;
  - c. the child has symptoms consistent with HIV infection;
  - d. a sibling has a diagnosis of HIV infection, initially tested positive for HIV infection but later seroreverted to negative, or died due to an HIV-related illness or AIDS;
  - e. the child was abandoned at birth and no risk history is available.
  
2. Risk factors related to the medical and psychosocial history of the child's mother or father, or a sexual partner of the child's mother or father, generally relevant only to an infant or young child through perinatal transmission:
  - a. the individual has a diagnosis of HIV infection, or symptoms consistent with HIV infection, or death due to HIV-related illness or AIDS;
  - b. the individual has or had a male sexual partner who has had sex with another man;
  - c. the individual has a history of sexually transmitted diseases, such as syphilis, gonorrhea, hepatitis B, or genital herpes;
  - d. the individual is known or reported to have had multiple sex partners or engaged in the exchange of sex for money, drugs, food, housing, or other things of value prior to the child's birth;
  - e. the individual has a history of tuberculosis;
  - f. the individual is known or reported to inject illegal drugs or share needles, syringes, or other equipment

- involved in drug use or body piercing;
- g. the individual is known to use non-injection illegal drugs, such as crack cocaine;
- h. the individual had a transfusion of blood or blood products between January 1978 and July 1985 in the United States of America; or
- i. the individual had a transfusion of blood or blood products in any other country at a time when the blood supply of that country was not screened for HIV infection.

3. Risk factors related to children and adolescents and associated with the child's behavior or with direct transmission from another person after the child's birth:

- a. the child has symptoms consistent with HIV infection;
- b. the child has been sexually abused;
- c. the child has engaged in sexual activity;
- d. the child has a history of sexually transmitted diseases, such as syphilis, gonorrhea, hepatitis B, or genital herpes;
- e. the child is known or reported to have had multiple sex partners or engaged in the exchange of sex for money, drugs, food, housing, or other things of value;
- f. the child has a history of tuberculosis
- g. the child is known or reported to inject illegal drugs or share needles, syringes or other equipment involved in drug use or body piercing;
- h. the child is known or reported to use non-injection illegal drugs, such as crack cocaine;
- i. the child had a transfusion of blood or blood products between January 1978 and July 1985 in the United States of America; or
- j. the child had a transfusion of blood or blood products in any other country at a time when the blood supply was not screened for HIV infection.

E. OBTAINING LEGAL CONSENT FOR HIV TESTING WHEN RISK IS IDENTIFIED

If the required HIV risk assessment for a child in foster care identifies one or more risk factors for the child, the authorized agency must obtain legal consent from an appropriate individual before the child's HIV test can take place.

1. When a child lacks capacity to consent and is placed in foster care under Article 10 of the Family Court Act as an abused or neglected child, or has been taken into or kept in protective custody or removed from the place where the child was residing pursuant to section 417 of the SSL or section 1022, 1024, or 1027 of the FCA, and HIV risk is identified, designated staff must:

- a. make a reasonable effort to inform the parent or guardian of the child of a positive HIV risk assessment and recommendation for testing;

b. request that the parent or guardian provide written permission within 10 business days for the testing of the child (see Appendix D for model form);

c. if permission signed and dated by the parent is received within the required timeframe, make an effort to discuss with the parent the parent's ability and willingness to accompany the child to the test site;

OR

explain to the parent that the agency will take responsibility for making arrangements for the testing, accompanying the child to the testing site, and providing the official consent signed by the commissioner or designated representative, keeping the parent informed of the procedures and results;

d. if there will be parental participation in the testing process, assist by arranging an appointment, providing transportation as needed, and informing the parent that staff at the testing site will provide pre- and post-test counseling and require the parent's signature on the official Department of Health informed consent form;

e. if the child's parent does not respond within the required timeframe, refuses to consent to the testing, or is unwilling or unable to participate in the testing procedures for the child, make arrangements for the HIV testing of the child and obtain the required written informed consent form (see Appendix C for the official form) signed by the commissioner or designated representative who must provide legal consent in such circumstances for the child's HIV test;

f. retain in the medical record section of the uniform case record a copy of the official Department of Health written consent form signed by the commissioner or designated representative and provided to the testing site.

2. When a child lacks capacity to consent, is placed in foster care as a result of parental surrender or termination of parental rights by the court, and HIV risk is identified, designated staff must:

a. make arrangements for the child to be tested;

b. obtain legal consent from the commissioner or designated representative who must provide the necessary signed official written informed consent on the Department of Health form (Appendix C);

c. retain a copy of the signed consent form provided to the testing site in the medical record section of the uniform case record.

3. When a child lacks capacity to consent, is placed in foster care voluntarily by his or her parents or by the court as a Person in Need of Supervision (PINS) or a Juvenile Delinquent (JD), and HIV risk is identified, designated staff must:

a. immediately inform the parent or guardian of the results of the assessment, and recommend testing;

b. explain testing procedures to the parent or guardian;

c. request written permission from the parent or guardian within 10 business days to make arrangements for HIV testing of the child (see model form in Appendix D);

d. if written permission is received, make arrangements for the test and for the parent or guardian to accompany the child to sign the official Department of Health written informed consent form at the test site;

e. if permission is denied by the parent or guardian, offer the parent/guardian the opportunity to meet with agency staff to discuss the assessment of risk factors and the importance of testing in order to provide medical care and services for any child who is HIV-infected;

f. if the parent/guardian continues to refuse permission, document that fact in the case record. Without parental consent, HIV testing of the child in this category cannot take place unless the agency secures a court order based on urgent medical necessity (as defined on pages 16-17 of this directive).

g. if the parent/guardian cannot be located, is incapacitated or deceased, seek a court order to allow for HIV testing.

4. When a foster child has been determined by the authorized agency to have the capacity to consent, and HIV risk has been identified, the child or youth has the right to make all decisions regarding an HIV test, the type of test, and a limited right to make certain decisions regarding disclosure of information related to an HIV test. Designated staff must respect these rights and must never use threats or coercion in an effort to persuade the child or youth to consent to testing.

In following required procedures to obtain consent from the child, the designated staff must:

a. inform the child of the results of the assessment of risk factors for HIV infection, including the specific risk factor(s) identified as the basis for the recommendation for HIV testing, and counsel the child regarding the benefits of being tested for HIV infection in order to receive medical care and services if an HIV infection is present;

b. inform the child that arrangements may be made for agency-supervised confidential HIV-related testing and that anonymous testing is available as an alternative;

c. provide information to the child of the requirements regarding the confidentiality of HIV-related information and the disclosures of confidential HIV-related information to certain persons and entities, as described in Section 441.22(b)(8) of Department regulations;

d. after providing the initial counseling and information to the child, ask the child whether he or she will agree to be referred for agency-supervised confidential HIV-related testing or anonymous testing;

e. if the child indicates that he or she will agree to be referred for agency-supervised confidential HIV-related testing, request that the child provide the authorized agency with written permission for such a referral and, within 30 business days of receiving such written permission, arrange for the HIV-related testing of the child including obtaining the necessary pre-test counseling for the child, written informed consent of the child and post-test counseling for the child in accordance with Article 27-F of the Public Health Law; OR

if the child indicates that he or she will agree to be referred for anonymous testing, offer to assist the child in obtaining access to an anonymous testing site; OR

if the child indicates that he or she will not agree to be referred for either form of testing, continue as part of the ongoing casework contacts with the child to discuss the importance of HIV related testing.

f. Regardless of whether a child who has the capacity to consent agrees to be referred for HIV-related testing, designated agency staff must continue to provide on-going counseling to the child regarding the importance of preventing and reducing behaviors that create a risk of HIV infection.

g. The child's decision pertaining to consenting or not consenting to HIV-related testing must be documented in the child's case record, and a copy of any signed written

agreement to be tested (see model form in Appendix E) also must be retained in the case record

h. Ensure that the child understands that, at any future time, the issues of HIV risk and testing may be reopened and discussed either at the request of the child or by agency staff.

Authorized agencies must inform certified foster parents, approved relative foster parents, and prospective adoptive parents that they do not ever have legal authority to provide written consent at a testing site for HIV testing of children placed in their care.

F. HIV TESTING OF CHILDREN IN FOSTER CARE

1. If a child in foster care is determined to have one or more of the risk factors listed in section IV. D of this directive, authorized agency staff must make arrangements for HIV testing to take place provided the required legal consent has been obtained:

a. within 30 business days of the child's entry into foster care if the initial assessment of the child indicated no possibility of capacity to consent (Please note that this timeframe is intended to correspond to the requirement for the child's initial comprehensive physical examination within 30 days of entry into care in accordance with section 421.22 of Department regulations and 90 ADM-21.);

b. within 60 business days of the child's entry into foster care if the initial assessment of the child indicated that there was a possibility that the child may have a capacity to consent, and the follow-up assessment completed within 30 days of entry resulted in a decision that the child did not have capacity to consent;

c. within 60 business days of the child's entry into foster care if the child was determined to have the capacity to consent and agreed to provide written consent to testing.

2. When a medical provider for the child in foster care recommends the HIV testing of the child based on medical/social history or symptoms, the authorized agency must begin immediately to initiate the procedures necessary to obtain legal consent before such testing can take place, unless the physician determines there is a medical emergency, in which case the physician may require the test be performed without consent. The child with capacity to consent retains the right in such situations to make his or her own decision regarding testing.

3. The HIV testing of a child or youth in foster care must be conducted:

a. under the direction of licensed medical personnel, who may be medical staff employed by the authorized agency or in designated testing centers or clinics;

b. at a designated testing center, medical facility or office.

4. Each service plan review and each periodic medical examination of a child that occurs after the initial assessment of the child pursuant to Section 441.22(b)(2) of Department regulations must include an assessment by designated agency staff of whether HIV-related testing is recommended based on the child's medical history and any information regarding the child obtained since the initial assessment of the child, the prior service plan review of the child or the prior periodic medical examination of the child, as applicable. If it is determined that HIV testing is recommended, the authorized agency must initiate the process to obtain legal consent. If the written informed consent for the HIV-related testing of the child is obtained, the agency must arrange for testing within 30 business days of the recommendation.

G. SERVICES REQUIRED FOLLOWING HIV TESTING OF A CHILD IN FOSTER CARE

If a child in foster care tests positive for HIV infection, the authorized agency must:

1. provide or arrange for counseling of the child as needed and age appropriate in addition to any post-test counseling at the test site (see pages 17-20 for a discussion of practice issues involved in providing or arranging counseling for the child, for foster parents, prospective adoptive parents, or the parent/guardian of the child);

2. arrange for all follow-up medical services needed by the child as a result of the HIV test, including any additional tests recommended by the child's medical provider;

3. provide support services and counseling as needed to the child's parents and foster parents caring for a child who tests positive for HIV infection.

H. DOCUMENTATION RELATED TO THE ASSESSMENTS AND HIV TESTING OF A CHILD IN FOSTER CARE

Authorized agencies must document specific information related to the assessments and HIV testing of a foster child in the uniform case record. The authorized agency must document the following information in the medical record section of the uniform case record:

1. decision on the assessment of the child's capacity to consent, reason for the decision, and the date of the decision;

2. confirmation that the assessment of HIV risk factors was conducted within required timeframes;

3. identification of any risk factors listed on pages 23 and 24 of this directive;
4. information on any follow-up assessments;
5. a copy of the written consent for HIV testing provided by the parent or guardian of the child, the child with capacity to consent, or the commissioner or designated representative, as applicable;
6. documentation of the parent's or child's refusal to provide consent, as applicable;
7. date and location of any HIV testing of the child;
8. type of HIV test:
  - a. confidential or anonymous (anonymous is a choice available in foster care only to the child/youth with capacity to consent);
  - b. antibody (elisa, western blot) or viral (polymerase chain reaction (PCR));
9. results of the HIV test and any recommendations by the medical provider for follow-up tests or medical treatment for the child;
10. information and counseling sessions provided to an HIV-infected child;
11. information and counseling sessions provided to the parent of an HIV-infected child without capacity to consent who has a permanency planning goal of return home;
12. information and counseling sessions provided to the parent of an HIV-infected child with capacity to consent only if the child/youth has provided written consent to provide such HIV-related information concerning himself or herself to the parent;
13. information and counseling sessions provided to the foster parents or prospective adoptive parents caring for an HIV-infected child;
14. specific plans for training and support services for foster parents or prospective adoptive parents caring for an HIV-infected child.

I. CONFIDENTIALITY AND DISCLOSURE OF HIV-RELATED INFORMATION CONCERNING THE FOSTER CHILD

All person-specific HIV-related information must be maintained in a confidential manner, as required by Section 431.7 of Department regulations. In all cases when HIV-related information is made available as described in this section, a warning statement against further disclosure or redisclosure must be provided to those

receiving such information except those persons listed in paragraph 4 of this section. (For a copy of the warning statement, see Appendix A.)

1. Authorized agencies must insure that direct access to HIV-related information concerning a foster child is limited to:
  - a. an authorized agency responsible for the foster care or adoption of such child;
  - b. staff within that authorized agency who need to know such information in order to supervise, administer, monitor, or provide services for the specific HIV-infected child or child's family;
  - c. the child's medical care provider or medical facility;
  - d. the child with capacity to consent;
  - e. a person authorized by law to consent to health care for a foster child who lacks capacity to consent.
  
2. Authorized agencies must disclose HIV-related information concerning a specific foster child, whether or not the child has capacity to consent, to the following:
  - a. certified foster parents and approved relative foster parents caring for the HIV-infected child;
  - b. prospective adoptive parents and adoptive parents of the child freed for adoption;
  - c. another authorized agency when the child is transferred to that agency or agency facility for placement or treatment;
  - d. the law guardian of the child;
  - e. a foster child discharged to his or her own care; and
  - f. an adopted former foster child upon request.
  
3. Authorized agencies must disclose HIV-related information concerning a specific foster child to the following only under certain conditions:
  - a. the parent or guardian of the foster child if the foster child lacks capacity to consent;
  - b. the parent or guardian of the foster child with capacity to consent only if the child provides written consent to disclosure of the information to the parent or guardian;
  - c. in a court hearing related to the foster child only when directly ordered by a judge after a hearing on the issue of

disclosure (such information must not be provided in response to a subpoena, in accordance with Public Health Law, Article 27-F);

d. external services providers only when necessary to obtain essential health or social services for the foster child and only when the commissioner or designee has signed specific authorization for the release of such information, including the reason for the release, the warning statement against any redisclosure, the signature and date of signature from the person receiving such information. Examples: psychologist, home aide, day care or school staff (day care or school staff only when medication or other medical necessity directly related to HIV infection or AIDS is involved). (See model form in Appendix B.)

4. The right of a person in #2 or #3 to redisclose confidential HIV-related information concerning a foster child is limited to the following persons:

a. a prospective adoptive parent of a foster child freed for adoption, or an adoptive parent, without condition;

b. a certified foster parent or approved relative foster parent caring for the child, only when necessary for the care, treatment or supervision of the child;

c. the law guardian of the child when necessary to represent the child without capacity to consent in court proceedings;

d. the law guardian of the child when necessary to represent the child with capacity to consent in court proceedings only if the child with capacity to consent has provided written consent for such disclosure.

J. RECRUITMENT OF FAMILIES TO CARE FOR HIV-INFECTED CHILDREN IN FOSTER CARE

Authorized agencies operating foster boarding home and/or adoption home programs must include in their community relations efforts information regarding the need for foster and prospective adoptive families who may be able and willing to provide care for HIV-infected children identified by these HIV assessment and testing requirements.

V. REPORTING AND SYSTEMS IMPLICATIONS

Each authorized agency is required to document the HIV risk assessment and testing, as appropriate, for each child in foster care in accordance with Department regulations and this directive.

VI. ADDITIONAL INFORMATION

Additional information is provided through Appendices attached to this directive.

Date July 24, 1997

Trans. No. 97 ADM-15

Page No. 33

VII. EFFECTIVE DATE

The effective date of this Administrative Directive is August 15, 1997, retroactive to August 23, 1995 which was the effective date of Department regulations requiring authorized agencies to implement the HIV assessment and testing program for New York State children in foster care.

---

Rose M. Pandozy  
Deputy Commissioner  
Division of Services and  
Community Development

APPENDIX A

WARNING NOTICE

AGAINST REDISCLOSURE

OF CONFIDENTIAL HIV-RELATED

INFORMATION

This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

(See other side for Spanish translation.)

NOTIFICACION DE ADVERTENCIA  
CONTRA LA REVELACION DE INFORMACION CONFIDENCIAL  
RELACIONADA AL HIV

La información que se le ha revelado proviene de récords confidenciales que están protegidos por la ley del Estado. La ley del Estado le prohíbe a usted proveer más revelaciones con respecto a esta información sin la aprobación específica de la persona a quien se refiere o sin el permiso de la ley. Cualquier revelación adicional que no esté autorizada constituye una violación de la ley del Estado y puede que resulte en una multa o una sentencia de cárcel o ambas. Una autorización general para proveer información médica u otro tipo de datos no constituye una autorización suficiente para hacer más revelaciones.

APPENDIX B

Authorization for Redisclosure of Confidential HIV-Related Information
[Please Note: This completed form must be returned to the agency responsible for the care of the child.]

Date \_\_\_\_\_

I hereby authorize redisclosure of confidential HIV-related information

by \_\_\_\_\_

(name of agency)

concerning \_\_\_\_\_

(child's name)

to \_\_\_\_\_

(person or agency)

for the following time period (check one):

\_\_\_ specific dates: \_\_\_\_\_

\_\_\_ while child remains in care of above-named person(s)

\_\_\_ until services are completed

The purpose for authorizing redisclosure as permitted by Article 27-F of the Public Health Law and Department regulations:

\_\_\_\_\_

I am legally permitted to authorize redisclosure because I am:

\_\_\_ the child named above

\_\_\_ the birth parent or legal guardian of the child (where the child lacks capacity to consent)

\_\_\_ the social services commissioner

\_\_\_ the designated representative of the commissioner (indicate title with signature)

Signature \_\_\_\_\_

Title (if appropriate) \_\_\_\_\_

Warning Statement on Redisclosure Except to Authorized Persons

This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

Receipt of Confidential HIV-related Information

I have received confidential HIV-related information and have read the warning statement required by law. I understand the penalties for further redisclosure without written permission.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(person receiving confidential information in order to provide services)

APPENDIX C

REQUEST FOR PARENTAL PERMISSION TO TEST CHILD FOR HIV INFECTION  
(For a child without capacity to consent)

I have been informed that my child, \_\_\_\_\_, has been found by the agency where he/she has been placed in foster care, to be at risk for HIV infection. The agency recommends testing to determine whether the child is infected so that care and treatment can be given as necessary.

I understand that the agency is requesting my permission for the child to be tested, and that this form must be returned to the agency within 10 business days.

I understand that if I give my permission for my child to be tested, the agency will make arrangements for the test.

If the agency asks me to go to the HIV test site with my child and I agree to go, I understand that I would be asked to sign the Department of Health consent form and receive pre-test counseling at the test site.

I would need transportation to the testing site in order to take my child.

Yes\_\_\_ No\_\_\_

If my child was placed in foster care by the court for abuse or neglect, I understand that the agency may give consent and arrange for my child to be tested for HIV even if I do not sign and return this permission slip or if I refuse to give my permission for the test.

If my child was placed in foster care for reasons other than protective removal or placement (abuse or neglect), I understand that the agency may not give consent and arrange for my child to be tested for HIV. My child will not be tested unless I give permission or a court order is obtained. If I give permission, I understand that I must go with my child to the testing site.

I give my permission for my child placed in foster care to be tested for HIV infection.

Yes\_\_\_ No\_\_\_

I understand that the agency will inform me regarding the results of the HIV test.

Signed by \_\_\_\_\_ (parent)

Date\_\_\_\_\_

Received by agency staff\_\_\_\_\_ (signature)

Date \_\_\_\_\_

APPENDIX D

DECISION REGARDING TEST FOR HIV INFECTION BY CHILD WITH CAPACITY TO CONSENT

I have been informed by agency staff that they believe I am at risk for HIV infection. Agency staff have explained the reason(s) why they believe I am at risk for HIV infection. I understand the importance of being tested in order to receive any necessary treatment and services.

I understand that if I agree to be tested, I will receive pre-test counseling at the testing site and will be asked to sign the official Department of Health written informed consent form.

I understand that if I agree to be tested, I may choose between confidential (agency-supervised) testing or anonymous testing (where I would be identified only by number).

I understand that I will be given the results of the test, whether confidential or anonymous. If I choose anonymous testing, no other person or agency will be given the results of the test. If I choose confidential testing, the agency will also receive the results of the confidential test, as will other persons required by law to be given the results. In either case, my parents could not be given the results without my written permission.

I understand that the agency will make arrangements for the test and for any necessary transportation to the test site.

I agree to be tested for HIV infection.

Yes \_\_\_\_\_ No \_\_\_\_\_

If I have checked "Yes," I choose:

Confidential testing \_\_\_\_\_  
Anonymous testing \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

Agency staff \_\_\_\_\_

Date \_\_\_\_\_

APPENDIX H

NEW YORK STATE INDEPENDENT LIVING TRAINING NETWORK  
WITH INFORMATION AND RESOURCES AVAILABLE ON ADOLESCENT ISSUES

Region 1:

Buffalo State College  
Center for Development of  
Human Services  
Campus West  
1300 Elmwood  
Buffalo, NY 14222

(716) 882-1117

Region 2:

Buffalo State College  
Center for Development of  
Human Services  
1210 Jefferson Road  
Rochester, NY 14623

(716) 292-5010

Regions 3 and 4:

State University of New York  
at Albany  
Professional Development Program  
135 Western Avenue  
Albany, NY 12222

(518) 442-5700

Region 5:

State University of New York  
at Stony Brook  
School of Social Welfare  
Stony Brook, NY 11794-8231

(516) 444-7565

Region 6:

South Bronx Human Development  
Center  
One Fordham Plaza, Suite 900  
Bronx, NY 10458

(718) 295-5501

**HIV AND AIDS RELATED INFORMATION**

**Section 2780. Definitions.**

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

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

- 1. "AIDS" means acquired immune deficiency syndrome, as may be defined from time to time by the centers for disease control of the United States public health service.**
- 2. "HIV infection" means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS.**
- 3. "HIV related illness" means any illness that may result from or may be associated with HIV infection.**
- 4. "HIV related test" means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or to indicate the presence of AIDS.**
- 5. "Capacity to consent" means an individual's ability, determined without regard to the individual's age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure, or of a proposed disclosure of confidential HIV related information, as the case may be, and to make an informed decision concerning the service, treatment, procedure or disclosure.**
- 6. "Protected individual" means a person who is the subject of an HIV related test or who has been diagnosed as having HIV infection, AIDS or HIV related illness.**
- 7. "Confidential HIV related information" means any information, in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV related information, concerning whether an individual has been the subject of an HIV related test, or has HIV infection, HIV related illness or AIDS, or information which identifies or reasonably could identify an individual as having one or more of such conditions, including information pertaining to such individual's contacts.**
- 8. "Health or social service" means any public or private care, treatment, clinical laboratory test, counseling or educational service for adults or children, and acute, chronic, custodial, residential, outpatient, home or other health care provided pursuant to this chapter or the social services law; public assistance or care as defined in article one of the social services law; employment-related services, housing services, foster care, shelter, protective services, day care, or preventive services provided pursuant to the social services law; services for the mentally disabled as defined in article one of the mental hygiene law; probation services, provided pursuant to articles twelve and twelve-A of the executive law; parole services, provided pursuant to article twelve-B of the executive law; correctional services, provided pursuant to the correction law; detention and rehabilitative services provided pursuant to article nineteen-G of the executive law; and the activities of the health care worker HIV/HBV advisory panel pursuant to article twenty-seven-DD of this chapter.**
- 9. "Release of confidential HIV related information" means a written authorization for disclosure of confidential HIV related information which is signed by the protected individual, or if the protected individual lacks capacity to consent, a person authorized pursuant to law to consent to health care for the individual. Such release shall be dated and shall specify to whom disclosure is authorized, the purpose for such disclosure and the time period during which the release is to be effective. A general authorization for the release of medical or other information shall not be construed as a release of confidential HIV related information, unless such authorization specifically indicates its dual purpose as a general authorization and an authorization for the release of confidential HIV related information and complies with the requirements of this subdivision.**

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

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

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

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

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

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

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

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

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

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

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

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

**(c) an explanation of the confidentiality protections afforded confidential HIV related information under this article, including the circumstances under which and classes of persons to whom**

disclosure of such information may be required, authorized or permitted under this article or in accordance with other provisions of law or regulation.

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

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

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

- (a) for coping with the emotional consequences of learning the result;
- (b) regarding the discrimination problems that disclosure of the result could cause;
- (c) for behavior change to prevent transmission or contraction of HIV infection; (d) to inform such person of available medical treatments; and
- (e) regarding the test subject's need to notify his or her contacts.

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

- (a) by a health care provider or health facility in relation to the procuring, processing, distributing or use of a human body or a human body part, including organs, tissues, eyes, bones, arteries, blood, semen, or other body fluids, for use in medical research or therapy, or for transplantation to individuals provided, however, that where the test results are communicated to the subject, post-test counseling, as described in subdivision five of this section, shall nonetheless be required; or
- (b) for the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher; or
- (c) on a deceased person, when such test is conducted to determine the cause of death or for epidemiological purposes.
- (d) conducted pursuant to section twenty-five hundred-f of this chapter.

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

- (a) the protected individual or, when the protected individual lacks capacity to consent, a person authorized pursuant to law to consent to health care for the individual;
- (b) any person to whom disclosure is authorized pursuant to a release of confidential HIV related information;
- (c) an agent or employee of a health facility or health care provider if (1) the agent or employee is permitted to access medical records, (2) the health facility or health care provider itself is authorized to obtain the HIV related information, and (3) the agent or employee provides health care to the protected individual, or maintains or processes medical records for billing or reimbursement;
- (d) a health care provider or health facility when knowledge of the HIV related information is necessary to provide appropriate care or treatment to the protected individual, a child of the individual, a contact of the protected individual or a person authorized to consent to health care for such a contact;

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

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

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

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

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

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

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

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

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

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

**(o) an employee or agent of the commission of correction, in accordance with paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, to the extent the employee or agent is authorized to access records containing such information in order to carry out the commission's functions, powers and duties with respect to the protected individual, pursuant to article three of the correction law.**

**(p) a law guardian, appointed to represent a minor pursuant to the social services law or the family court act, with respect to confidential HIV related information relating to the minor and for the purpose of representing the minor. If the minor has the capacity to consent, the law guardian may not redisclose confidential HIV related information without the minor's permission. If the**

minor lacks capacity to consent, the law guardian may redisclose confidential HIV related information for the sole purpose of representing the minor. This paragraph shall not limit a law guardian's ability to seek relief under section twenty-seven hundred eighty-five of this chapter.

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

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

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

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

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

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

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

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

(b) When making such disclosures to the contact, the physician or public health officer shall provide or make referrals for the provision of the appropriate medical advice and counseling for coping with the emotional consequences of learning the information and for changing behavior to

prevent transmission or contraction of HIV infection. The physician or public health officer shall not disclose the identity of the protected individual or the identity of any other contact. A physician or public health officer making a notification pursuant to this subdivision shall make such disclosure in person, except where circumstances reasonably prevent doing so.

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

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

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

5. (a) Whenever disclosure of confidential HIV related information is made pursuant to this article, except for disclosures made pursuant to paragraph (a) of subdivision one of this section or paragraph (a) or (e) of subdivision four of this section, such disclosure shall be accompanied or followed by a statement in writing which includes the following or substantially similar language: "This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure." An oral disclosure shall be accompanied or followed by such a notice within ten days.

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

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

(b) Confidential HIV related information relating to a recipient of such service may be disclosed in accordance with regulations promulgated pursuant to paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article to an authorized employee or agent of such provider or government agency, when reasonably necessary for such supervision, monitoring, administration, or provision of such service. The term "authorized employee or agent", as used in this subdivision shall only include any employee or agent who would, in the ordinary course of business of the provider or government agency, have access to records relating to the care of, treatment of, or provision of a health or social service to the protected individual.

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

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

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

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

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

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

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

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

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

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

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

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

**4. Any cause of action to recover damages based on a failure to provide information, explanations, or counseling prior to the execution of a written informed consent, or based on a lack of informed consent in the ordering or performance of an HIV related test in violation of this article shall be governed by the provisions of section two thousand eight hundred five-d of this chapter.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

victim indicated in the order or consent and must also disclose the results to the person tested, unless the person tested has been asked to but declines to authorize such disclosure to himself or herself.

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

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

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

2. (a) Each state agency authorized pursuant to this article to obtain confidential HIV related information shall, in consultation with the department of health, promulgate regulations: (1) to provide safeguards to prevent discrimination, abuse or other adverse actions directed toward protected individuals; (2) to prohibit the disclosure of such information except in accordance with this article; (3) to seek to protect individuals in contact with the protected individual when such contact creates a significant risk of contracting or transmitting HIV infection through the exchange of body fluids, and (4) to establish criteria for determining when it is reasonably necessary for a provider of a health or social service or the state agency or a local government agency to have or to use confidential HIV related information for supervision, monitoring, investigation, or administration and for determining which employees and agents may, in the ordinary course of business of the agency or provider, be authorized to access confidential HIV related information pursuant to the provisions of paragraphs (l) and (m) of subdivision one and subdivision six of section twenty-seven hundred eighty-two of this article; and provided further that such regulations shall be promulgated by the chairperson of the commission of correction where disclosure is made pursuant to paragraphs (n) and (o) of subdivision one of section twenty-seven hundred eighty-two of this article.

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

**and scientific knowledge on the transmissibility of HIV infection, and any recommendations for changes in said regulations.**

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

# Health Services for Children in Foster Care: Consent and Confidentiality

## Statutory and Regulatory Authority

### Consent for Routine Care

SSL 383-b  
18 NYCRR 441.22(d)  
FCA 355.4.2  
NY Penal Law 70.20,4(b)(c)  
PHL 2504

### Consent for Emergency Care

18 NYCRR 441.22(d)  
PHL 2504(4)

### Informed Consent

PHL 2805-d

### Reproductive Health Services

PHL 2504(3)  
PHL 2305  
PHL 2306  
U.S. Supreme Court, 1977, 431  
U.S.678, Carey v. Population Services  
International

### Consent by Minor

MHL 33.21  
MHL 22.11  
PHL 3123

### Obtaining Records

18 NYCRR 441.22(e)  
42 U.S.C. Chapter 7, 675(1)(c)  
PHL 18

### Maintaining Records

SSL 372  
18 NYCRR 357(5) and (6)  
18 NYCRR 428.3(b)(4)(iii)  
18 NYCRR 431.7  
18 NYCRR 441.7(a)(1)  
18 NYCRR 441.22(k)

### Disclosing Records

45 CFR 164.512(a)  
CPLR 3122  
SSL 373-a  
PHL 2782  
PHL Article 17  
18 NYCRR 357(1) and (2) and (3)  
18 NYCRR 431.7  
18 NYCRR 443.2(e)(3)

### Miscellaneous

PHL 2504(5) (religious objection to  
immunizations)  
PHL Article 29-b (DNR requests)  
PHL Article 43 (organ donation)

SSL is Social Services Law  
NYCRR is New York Codes, Rules and Regulations  
PHL is Public Health Law  
MHL is Mental Hygiene Law  
FCA is Family Court Act  
CFR is Code of Federal Regulations  
U.S.C is U.S. Code  
CPLR is Civil Practice Laws and Rules