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IDENTIFYING SERVICES TO BE PROVIDED

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IDENTIFYING SERVICES TO BE PROVIDED

12.1 Introduction

To achieve better outcomes for the children and families involved with the child welfare system, the planning and delivery of services should focus on:

- Preventing further abuse and neglect.
- Preventing unnecessary separation of children from their homes.
- Minimizing how long children stay in foster care.
- Finding and sustaining stable, permanent families for all children.
- Meeting the social and emotional well-being needs of children, including addressing:
 - Needs from experiencing maltreatment, trauma, and/or exposure to violence.
 - Health needs (developmental, physical, medical, and dental needs).
 - Behavioral health needs (needs related to mental health & substance use disorders).
 - Educational needs.
- Respecting the cultural heritage and connections to family, community, and social support networks of children.

Families should be at the center of services that prevent and remedy situations that lead to child abuse and neglect. An array of services for children and their families should be available, from the first awareness that a family is at risk, to early intervention, to foster

care for those children whose safety and well-being is threatened, through permanency and the services necessary to sustain permanency.¹

12.2 Framework

Local departments of social services (LDSS) shall meet federal and state legal requirements and should use sound practice principles to achieve desired outcomes and to guide decision making in providing foster care services for children and their families.

12.2.1 Practice principles

Three fundamental principles inherent in Virginia's Children's Services System Practice Model guide service delivery include:

First, we believe that all children and communities deserve to be safe.

- Safety is primary. Every child has the right to live in a safe home, attend a safe school and live in a safe community. Ensuring safety requires a collaborative effort among family, agency staff, and the community.

Second, we believe in family, child, and youth-driven practice.

- It is our responsibility to understand children, youth, and families within the context of their own family rules, traditions, history, and culture.
- Children, youth, parents, and family members are partners in decision making on service and educational planning and in placement decisions, whenever appropriate.

Third, we believe that all children and youth need and deserve a permanent family.

- Children have a right to connections with their biological family and other caring adults with whom they have developed emotional ties.
- Services should be high quality, timely, efficient, and effective.
- We partner with others to support child and family success in a system that is family-focused, child-centered, and community-based.
- Services to families shall be delivered as part of a total system with cooperation, coordination, and collaboration occurring among families, service providers, and community stakeholders.

¹ Adapted from the "[Child Welfare League of America Statement on Optimal Child Welfare Service Delivery](#)".

- All stakeholders share responsibility for child safety, permanency, and well-being.

12.2.2 Legal citations

The legal framework and specific requirements for providing services to families are delineated in state law. See the law for complete language by clicking on the citations.

- **Foster care services**
 - [§ 63.2-905](#)
- **Children's Services Act (CSA)**
 - §§ [2.2-5200](#) through [2.2-5214](#)
- **Education requirements when placing child**
 - **Ensure educational stability for the child**
 - [Social Security Act, Title IV, § 475 \(1\) \(G\) \[42 USC 675\]](#)
 - [The Child and Family Services Improvement and Innovation Act; Public Law 112-34](#)
 - [§ 63.2-900.3](#)
 - [§ 22.1-3.4](#)
 - **Notify new school of placement; records; enrollment**
 - [§ 63.2-900 D](#)
 - [§ 22.1-3.4](#)
 - [§ 22.1-289 E](#)

12.2.3 Outcomes

Providing effective, quality and timely services for children in foster care is essential to achieving outcomes required in the federal Child and Family Services Review. The outcomes and specific measures are listed below:

Outcome 1: Families have enhanced capacity to provide for their children's needs.

- Needs and services of child, parents, and foster parents are assessed and met.

Outcome 2: Children have permanency and stability in their living situations.

- More children leave foster care and achieve permanency.
- Children achieve permanency with shorter lengths of stay in foster care.
- Increased timeliness to permanency.
- Fewer placement moves and disruptions.
- Fewer children in out-of-home care.
- More children placed in family-based care.
- More children placed in relative foster homes.
- Fewer children placed in residential care.
- Fewer children re-enter out-of-home care.

Outcome 3: The continuity of family relationships and connections is preserved for children.

- More children in foster care placed in close proximity to families and communities.
- More children in foster care placed with their siblings.

Outcome 4: Children receive adequate services to meet their physical and mental health needs.

- Children's health needs are assessed upon entering foster care.
- Children's physical health needs are met consistently.
- Children's dental health needs are met consistently.
- Children's trauma needs are met consistently.
- Children's behavioral health needs are met consistently.

Outcome 5: Children receive appropriate services to meet their educational needs.

- Children's educational needs are assessed and met.

12.3 Identifying services based on strengths and needs

Once a comprehensive assessment of the child and family has been completed, the service worker, the Family Partnership Team, and/or the Family Assessment and Planning Team (FAPT) should brainstorm creative ways to build upon the strengths, resources, and natural supports of the child and family to meet their unique needs.

Additional resources that can help identify services based on the child's needs include:

- Virginia Commission on Youth's [Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs](#) and its [Reference Chart of Disorders and Evidence-based Practices](#).
- SAMHSA's [National Registry of Evidence-based Programs and Practices \(NREPP\)](#) provides a searchable online registry of mental health and substance interventions available for implementation.
- California Evidence-Based Clearinghouse for Child Welfare (CEBC) [Topic Areas](#) provide child welfare professionals with easy access to information about selected child welfare related programs. This interactive search enables the service worker to search based on specific criteria and then browse through a wide range of programs that match that criteria.
- Blueprints for Healthy Youth Development [Program Selector](#) on model and promising programs, includes problem behavior, education, emotional well-being, physical health, and positive relationships.
- [Evidence-Based Treatments for Children and Adolescents: An Updated Review of Indicators of Efficacy and Effectiveness](#) by Bruce Chorpita, et al. 2011. This updated review of evidence-based treatments follows the original review performed by the Hawaii Task Force. Over 750 treatment protocols from 435 studies were coded and rated on a 5-level strength of evidence system. Results showed large numbers of evidence based treatments applicable to anxiety, attention, autism, depression, disruptive behavior, eating problems, substance use, and traumatic stress. Provides a list of options and information available to guide decisions about treatment selection.

12.4 Wraparound approach

LDSS should use a wraparound approach to help achieve the child's permanency goal and well-being and to address the child and family's needs. The process involves an intensive, individualized process for planning, implementing, and managing care to achieve positive outcomes with the child and family.

A team of people, relevant to the child’s life, collaboratively develops and implements a creative wraparound plan. This holistic plan is designed based on an assessment of the needs of the child, caregivers, and siblings. A wraparound set of services and supports is individually designed with the child and family to meet their identified needs. The services creatively build upon and enhance the unique strengths, resources, and natural supports of the child and family.

The planning process, as well as the services and supports provided, are individualized, family-driven, culturally-competent, youth-guided, and community-based. The process and plan are strengths-based, including activities that purposefully help the child and family recognize, use, and build their talents, assets, and positive capacities.

The process strives to develop the coping skills, problem-solving skills, and self-efficacy of the child and family members. It increases the “natural support” available to the family by strengthening their interpersonal relationships and using other available resources in the family’s network of social and community relationships. It emphasizes integrating the child into the community and building the family’s social support network.²

For more information and practical tools on the wraparound process:

- The [CSA website](#) has training slides developed by expert consultants in wraparound strategies that were used in Virginia. It also provides links to national resources.
- The [National Wraparound Initiative](#) (NWI) convened national experts to define the wraparound practice model, develop standards, compile resources, strategies and tools, and disseminate guidance and information on high quality wraparound implementation to achieve positive outcomes for youth and families.
- The NWI “[Resource Guide to Wraparound](#)” provides information on the basics, principles, theory and research, wraparound practice, and supports for implementation.

12.5 Serving children in their homes and communities

Children who have significant emotional, behavioral, and mental health needs can successfully live in family homes and communities with the support of effective behavioral health services. Over the past twenty years, two major federal initiatives addressed the needs of children and youth with significant mental health conditions: Substance Abuse and Mental Health Services Administration’s (SAMHSA) Children’s Mental Health Initiative (CMHI) and the Centers for Medicare & Medicaid Services (CMS) Psychiatric Residential Treatment Facility (PRTF) Demonstration Program. Results from these programs across the country have consistently found that the implementation of home and community-based services for this population have made significant improvement in the quality of life for these children, youth, and their families.

² Adapted from Wraparound Basics on the [National Wraparound Initiative website](#).

Results from these federal initiatives have demonstrated that the provision of home and community-based services resulted in:

- More stable living situations.
- Increased behavioral and emotional strengths.
- Improved clinical and functional outcomes.
- Reduced suicide attempts.
- Improved school attendance and performance.
- Improved attendance at work for caregivers.
- Decreased contacts with law enforcement.
- Reduced costs of care.

Programs in these federal initiatives that helped achieve these results include:

- Intensive Care Coordination - Wraparound Approach.
- Peer Services: Parent and Youth Support Services.
- Intensive In-Home services.
- Respite services.
- Mobile crisis response and stabilization services.
- Flex funds.³

For more information on these results and services, see information bulletin on [Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions](#).

Examples of evidence-based programs that have also demonstrated results of serving children in the community include:

- [Multisystemic Therapy](#) (MST).
- [Functional Family Therapy](#) (FFT).

³ Information in this section excerpted and adapted primarily from Joint CMCS and SAMHSA Informational Bulletin on [Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions](#) dated May 7, 2013.

- Multidimensional Treatment Foster Care.
- Attachment and Biobehavioral Catch-up (ABC)
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT).

12.5.1 Children who are victims or at risk of human trafficking

Human Trafficking refers to both sex and labor trafficking. Severe forms of trafficking include: sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or labor trafficking which is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

Sex Trafficking is a multi-billion dollar industry⁴ worldwide and it is rapidly growing in the United States and in Virginia. Research suggests that children currently or formerly in foster care are at higher risk of being trafficked. Common risk factors⁵ include but are not limited to:

- Limited or severed family connections;
- Gang affiliations;
- History or current episode of runaway (See [Section 17.13.5](#) for screening after a runaway episode);
- A history of trauma, physical or sexual abuse; and,
- Prior involvement with law enforcement.

The Preventing Sex Trafficking and Strengthening Families Act of 2014 ([P.L.113-183](#)) requires states to make efforts in identifying, documenting and determining the appropriate services specifically for children and youth who are victims or at risk of being sex trafficked. This applies to children who:

- Are under the age of 18 and in the placement, care or supervision of a title IV-E agency.
- Are under the age of 18, have an open case with a LDSS agency but were not removed from their home.

4 International Labour Organization (Geneva 2014). [Profits and poverty: the economics of forced labour.](#)

5 Department of Health and Human Services Administration for Children, Youth and Families (2014). [Guidance to states and services on addressing human trafficking of children and youth in the United States.](#)

- Are under the age of 18 and have run away from foster care.
- Are between the ages of 18 and 21 and in the Fostering Futures Program.

The information obtained in this process may assist in identifying characteristics, signs and vulnerabilities to respond to youth who have been sex trafficked and inform communities how to help combat future incidents. The LDSS shall report within 24 hours to law enforcement after receiving information on a child or youth who has been identified as being a sex trafficking victim. Additionally, LDSS should assess and identify any factors that may place the child or youth at a heightened risk for sex trafficking.

LDSS are also required to complete human trafficking assessments for all complaints or reports alleging that a child is victim of human trafficking, unless it is determined an investigation or family assessment is required (as outlined in [Section 12.5.1.2](#)). If the child has been a victim of human trafficking, the LDSS must complete the assessment on the child and implement services that can assist the child and family.

If the child is identified as a victim of sex trafficking at any point in the foster care case, the service worker must update the sex trafficking screen under the client in the foster care case to indicate the child was a victim of sex trafficking.

12.5.1.1 Services for children who are victims or at risk of sex trafficking

When determining the services for children who were victims or at risk of sex trafficking, the service worker shall consider several factors when developing a treatment plan and document efforts made to provide appropriate services in the youth's foster care plan. These factors include:

- Access to safe and suitable housing.
- A safety plan to keep perpetrators away from the victim and his/her treatment setting.
- A safety plan for youth who have been trafficked should they be approached by the perpetrator when away from the treatment setting.
- Access to trauma-informed evidence based mental health services by experienced professionals in complex trauma.
- Access to physical health services, STD testing, and specialized care such as OB/GYN or drug rehabilitation.
- Access to legal services.

- Access to rehabilitative service including counseling, education and job training.
- Access to services that may reduce their risk factors for sex trafficking, such as sex trafficking prevention programs, healthy relationships programs, educational support, counseling or other treatment programs.

Service workers should explore community-based services that are trauma-informed and evidence-based that can be provided to the child or youth in the least-restrictive, most family-like setting.

12.5.1.2 Placements for youth who are victims or at risk of sex trafficking

Service workers must ensure that children and youth who are victims or who are at risk of sex trafficking are placed in settings that are the least restrictive, the most family-like, and that are safe and appropriate for the youth (i.e. a family foster home). If safety factors require a higher level of care (i.e. congregate care), service workers should explore whether the child's emotional, behavioral, or other treatment needs would qualify them for a psychiatric treatment facility or a qualified residential treatment program (See Section 6B) as these programs would have the most therapeutic support available.

VDSS has formed partnerships with other state agencies to work towards enhancing capacity in Virginia for high quality residential services targeted at providing services specifically for children who are victims of human trafficking and services to reduce the risk of human trafficking for those children who are at heightened risk. Once high quality congregate care programs are available with these qualifications, IV-E funding may be used to fund these placements, even if the facility isn't designated as a qualified residential treatment program.

12.5.1.3 Human trafficking assessments and children and youth in foster care

Beginning July 1, 2019, the Code of Virginia (§ [63.2-1506.1](#)) requires all LDSS to complete a human trafficking assessment for all complaints or reports alleging that a child is victim of human trafficking, unless it is determined an investigation or family assessment is required. Human trafficking includes sex and labor trafficking.

- All complaints or reports alleging a child is a victim of human trafficking require the LDSS to complete a human trafficking assessment, unless during the course of the human trafficking assessment it is determined an investigation or family assessment is required by law or is necessary to protect the safety of the child. The completion of a human trafficking

assessment does not require the complaint or report meet the four validity criteria outlined in [22 VAC 40-705-50 B](#). The completion of an investigation or family assessment on a complaint or report alleging a child is a victim of human trafficking requires a valid complaint or report and each of the four validity criteria outlined in [22 VAC 40-705-50 B](#) must be satisfied. ([Section 4.2](#) of Child Protective Services guidance)

When service workers receive information of a human trafficking incident involving a child in foster care, the service worker must make a child protective services report to the locality where the human trafficking occurred or was discovered. This will allow the locality to review the report and determine if an investigation or family assessment is required by law or is necessary to protect the safety of the child. If the locality determines the report is invalid, that locality will screen out the report and open a human trafficking assessment from the invalid referral.

For youth in foster care, the human trafficking assessment will be a separate case from the foster care case in the child welfare information system. In order to maintain the integrity of the foster care case and comply with the requirements of the human trafficking assessment, it is crucial not to change the case type from foster care to human trafficking assessment.

In cases where the locality with custody of the youth and the locality where the human trafficking occurred or was discovered are different, the locality with custody of the youth will have primary assignment and the locality where the trafficking occurred or was discovered may have a secondary assignment to ensure the child's immediate safety if there is significant distance and the locality with custody of the youth cannot respond immediately. This is different from how Child Protective Services cross-jurisdictional cases are typically handled. However, since the locality with custody of the youth is already responsible for ensuring the youth receives services and has a relationship with the youth, assigning this locality as primary prevents duplication of services and efforts.

When the locality with custody of the youth and where the human trafficking occurred or was discovered are the same, the locality can determine case assignment in their locality. It is recommended that the human trafficking assessment be a joint case between foster care and child protective services. The foster care service worker is familiar with the child and family and is already providing services through the foster care case. However, child protective services can help ensure that human trafficking guidance is followed and the corresponding screens are completed. Agencies may assign prevention workers to these cases as well. Agencies have autonomy and flexibility to determine what works best to serve the youth in their care.

12.5.1.4 Resources

- [Human Trafficking Screening Tool](#).
- [Building Child Welfare Response to Sex Trafficking \(includes screening tools\)](#)
- [VDSS public website](#).
- [The Polaris Project](#).
- [The National Human Trafficking Resource Center](#).
- [Identifying Minors and Young People Exploited Through Sex Trafficking: A Resource for Child Welfare Agencies](#)

12.5.2 Safety Services

Child and family safety must be continuously assessed in every child welfare program area throughout the life of the case (See [Section 17.8.1](#) and the [Home Visit Guidance Tool](#)). Safety assessment is both a process and a product. A continuum of immediate protective intervention and safety services must be initiated throughout the life a child welfare case whenever safety issues are identified.

Safety services are formal or informal services provided to or arranged for the family with the explicit goal of ensuring the child's safety. These services must be immediately available and accessible and may be provided by professionals, family members or other willing parties as long as each involved individual understands their role and responsibility. The safety services must be clearly documented (i.e. safety plan, foster care plan, court order, etc.) for the involved parties and in the case record.

In foster care cases, safety services may be put in place in response to a CPS allegation in a foster home, addressing safety issues during a trial home visit, and whenever there is a safety issue identified regardless of the child's placement. Safety services can be concrete items such as purchasing child locks or child care or they can be a service such as respite.

As with all aspects of case planning, the family should be engaged in providing input and joint decision making throughout the process of identifying, implementing, and evaluating these interventions and safety services. Documentation in the automated child welfare system must clearly demonstrate how the actions taken provided the child with immediate protection from the safety issue and how each safety service contributes to addressing or eliminating the safety matters specific to the child.

Some of examples of safety services in foster care cases include:

- Child has significant behavioral needs and entered foster care due to physical abuse by the mother. After sufficient progress on foster care plan goals, the LDSS is prepared to start a trial home visit. Safety concerns still exist regarding the mother's ability to manage the child's behaviors continuously without escalation. During the FPM prior to the trial home visit, the agency put in place the safety service of respite provided by the child's foster parent. This service is available immediately and will continue throughout the trial home visit. Mom will access the service as needed and on a preventative basis as well. The service was documented as part of the FPM record in the OASIS and was documented in the foster care plan review that was submitted to court.
- Child is three years old and was placed immediately in a foster home upon entry into foster care. During his first night of placement, the child woke up in the middle of the night, dragged a chair to the front door, and unlocked all the locks. The child walked to another home on the neighboring street and was found by the homeowner. The police were called and LDSS was subsequently notified. Due to the safety concern identified, the safety service of purchasing safety locks for the family was put in place. The LDSS immediately assisted the foster family with purchasing and installing the safety locks on all entrances. The service was documented in the child's foster care plan and case contacts.

12.6 Infant and toddler early intervention services

The [Infant & Toddler Connection of Virginia](#) provides early intervention supports and services to infants and toddlers from birth through age two who are not developing as expected or who have a medical condition that can delay normal development. To determine eligibility, the child's development is evaluated by at least two professionals from different professions or areas of development. When eligible, the family and professionals develop an Individualized Family Service Plan (IFSP).

12.7 Head Start and Early Head Start

Children whose families are served by the child welfare system often are developmentally vulnerable due to trauma stemming from early abuse and neglect as well as from risk factors that commonly co-occur, such as prenatal drug exposure, prematurity, low birth weight, poverty, homelessness, parent's depression and other mental health problems. The comprehensive services offered by Head Start and Early Head Start programs support children by providing a safe and enriched learning environment while facilitating early identification of developmental delays and access to early intervention, health care and mental health services. In addition, Head Start and Early Head Start programs provide a significant source of family support, parent education and adult developmental services for parents and other family members.

Foster children who meet program age requirements are automatically eligible for Head Start and Early Head Start even if the family or foster family income exceeds income guidelines.

Children whose custodial parents have an open case with the child welfare system but retain physical custody of their children are not automatically eligible for Head Start or Early Head Start, but a program may prioritize these children for enrollment due to the level of risk and the needs of the family.

Additional information on locating and enrolling in a local Head Start program may be found on the [Virginia Head Start Association, Inc.](#) website.

12.8 Child care services

12.8.2 Choosing allowable child care provider

The LDSS holding custody of a child shall consult with the foster/adoptive parent when selecting a child care provider. Considerations when making decisions about which provider to use include such things as the special needs of the child, travel distance from the foster/adoptive home, availability of the provider, provider costs in relation to other providers in the area, approval status of the provider, and the foster/adoptive parent request for specific services. Children's special needs include characteristics such as developmental disabilities, intellectual disabilities, emotional disturbance, sensory or motor impairment, or significant chronic illness which require special health surveillance or specialized programs, interventions, technologies, or facilities.

The providers identified below are considered as legally operating in Virginia and are allowable for child care services and payment from title IV-E funds. Authorization of the provider's status shall be verified online prior to use of the provider and a hard copy of the authorization shall be maintained in the case record of the child. See the VDSS [public website](#) for contact information for verifying the status of specific daycare providers listed below.

- Voluntary registered family day homes.
- Licensed family day homes.
- Licensed child day centers.
- Certified pre-schools.
- Religiously exempt child day centers.
- Department of Education-approved child care facilities.

- Local ordinance-approved providers (available in Fairfax County, Alexandria, Arlington).
- Family day system homes

12.8.3 Rates for child care

Localities shall make a diligent effort to secure fully approved child care for foster children at costs no greater than the established maximum reimbursable rates. These rates are established in accordance with federal regulatory requirements.

Rates are determined by type of provider, number of hours the child is in care, and the age of the child, as described below. For more information, see the Division of Child Care and Early Childcare Development, [Child Care Guidance](#).

- **Provider type.** Two levels of maximum reimbursable rates shall be used based on the type of provider. The LDSS shall have a written agreement with the provider for child care services. The types of providers for each rate level are listed in Appendix E of the Child Care Guidance manual.
- **Number of hours in care.** The unit price for services shall be based on whether the child is in child care for a full day (five (5) or more hours a day) or a part day (fewer than five (5) hours for a day).
- **Age groupings.** Rates shall be based on the age of children, as defined by the VDSS Division of Licensing Programs for child day centers:
 - Infants. Children from birth up to 16 months.
 - Toddlers. Children from 16 months up to 24 months.
 - Preschool. Children from 24 months up to the age of eligibility to attend public school (five years by September 30). Children turning five after September 30 are considered pre-school until they start school the following year.
 - School age. Children eligible to attend public school, age five or older by September 30 of that same year. Children turning five after September 30 are considered pre-school until they start school the following year. The School Age rate is effective starting the first Monday in September for all children who turn age 5 before September 30th.

The maximum reimbursable rates for child care are listed for each locality by full day and part day for each age group in the CCD Manual.

- Level 1 rates are listed in Appendix L.

- Level 2 rates are listed in Appendix M.

If the LDSS has made a diligent effort to secure child care at or lower than the maximum reimbursable rate and cannot locate a provider willing to accept that rate, the LDSS may choose to pay more if it is determined to be a reasonable cost. Reasonableness is determined based on the considerations used in selecting the provider. Providers whose costs cannot be justified as “reasonable” in comparison to costs charged by similar providers should generally not be used.

The service worker shall document in the case record the efforts made to secure the maximum reimbursable rate and factors used to determine reasonable cost.

12.8.4 Funding sources

Allowable title IV-E expenditures:

Child care is an allowable title IV-E expenditure when the child care:

- Provides daily supervision during the foster parents working hours when the child is not in school.
- Facilitates the foster parent’s attendance at activities which are beyond the scope of “ordinary parental duties.”
- Is provided in a licensed day care facility or home.

As examples, child care is an allowable expenditure under title IV-E for the foster parent to attend:

- Judicial or administrative reviews.
- Mandated team meetings by the court or the LDSS.
- Approved foster parent training.
- College classes when the foster child is not in school.

Not allowable title IV-E expenditures:

Child care provided to a child in foster care cannot be paid with title IV-E to facilitate a foster parent’s participation in activities that are:

- Within the realm of “ordinary parental duties.”
- Deemed a social service.

As examples, the following activities are not allowable expenditures under title IV-E:

- Illness of the foster parent.
- Respite care.
- School conferences.

State pool (CSA) funds are used to fund child care for non-title IV-E children. The use of state pool funds for child care is governed by federal and state requirements for the provision of child care services to foster care children. State pool funds may not be used to circumvent federal and state requirements for the provision of services, i.e. to pay for a non-licensed provider, or to pay for circumstances disallowed by title IV-E such as activities that are within the realm of “ordinary parental duties”.

12.9 Respite care services

Respite care is a therapeutic support service designed to offer short-term relief to families caring for children by providing substitute care for children. The purpose of respite care for families, including foster families, is to reduce foster home disruption and provide a stable foster care placement for the child. It can be provided on an emergency or planned basis. The following requirements shall be met:

- The respite care provider shall be approved by the LDSS (See “[Local Department Foster and Adoptive Home Approval Guidance Manual](#)”).
- Respite care can be provided for up to 30 days per year. If more than 30 days per year is needed for a child with special needs, the reasons for the need for additional respite care should be documented in the record. Respite care should not extend beyond 60 days per year.
- Respite care is not the provision of an emergency placement when a placement has disrupted, or short-term placement of a child in a residential facility for the purposes of treatment.
- The LDSS shall assure that a basic orientation to the agency's mission and goals, policies, and procedures related to medical treatment, emergencies, liability, transportation, confidentiality, and information about the child is provided to the respite care provider prior to the commencement of services.
- While the child is receiving respite care, the foster parents shall continue to receive foster care maintenance payments.

12.10 Transportation services

12.10.2

Travel of children in foster care

Decisions regarding children in foster care traveling out of state and/or out of the country should be made according to policies regarding normalcy for children in foster care. [See section 6.8.](#) The caregivers should consider the child's foster care plan including the child's school schedule, visitation schedule, treatment needs, etc. (The decision should be made with input from the child's team, including the birth family.)

12.10.2.1 Requirement for approved child restraint devices

- Children through age seven (until their 8th birthday), transported in a vehicle by LDSS staff, foster care providers, or any adult transporting a child, shall be properly secured in a child-restraint device of a type approved by the United States Department of Transportation. There is no height or weight requirement; age is the only requirement.
- Rear-facing child restraint devices shall be placed in the back seat. If the vehicle does not have a back seat, the child-restraint device may be placed in the front seat if the passenger side does not have an air bag or if it has been deactivated ([§ 46.2-1095](#)).

Safety seat installation videos are available in English and Spanish at the [Virginia Department of Health website](#).

Exceptions for certain children who may be exempted from the requirements for an approved restraint device in the following situation:

- If a physician states that use of a child-restraint device would be impractical because of the child's weight, physical unfitness, or other medical reasons. The driver shall carry or keep in the vehicle a statement signed by the physician giving the child's name and the grounds for exemption ([§ 46.2-1096](#)).
- A seat belt which is standard equipment in automobiles may be used for children at least four (4) years old but less than eight (8) year old when the driver carries or keeps in the vehicle a signed written statement of a physician that the child's weight, physical fitness, or other medical reasons makes the use of a child-restraint system impractical. The statement shall give the child's name and the grounds for exemption ([§ 46.2-1100](#)).

Violation is sufficient for ticketing; no other violations need be committed prior to ticketing. There is a civil penalty of \$50.00 for failure to have a

child in a child restraint device. Subsequent violations on different dates will be fined up to \$500.00.

There is an additional \$20.00 penalty for failure to carry a physician's written statement for a child exempted from the law due to medical reasons ([§ 46.2-1098](#)).

- Children age eight (8) and through age 17 (until their 18th birthday), transported in a vehicle by LDSS staff, foster care providers, or any other adults transporting the children shall be correctly secured by an appropriate safety belt ([§ 46.2-1095](#)).
- Violation is sufficient for ticketing; no other violations need be committed prior to ticketing. There is a civil penalty of \$25.00 for failure to have a child correctly buckled.
- Children through age 15 (until 16th birthday) shall not be transported in the rear cargo area of a pickup truck, except for certain parades and farming activities ([§ 46.2-1156.1](#)).

12.10.2.2 How to pay for restraint devices

Free child safety seats are available for eligible families who cannot afford them. To qualify, applicants shall meet all of the following:

- Parent, legal guardian, or foster parent of the child.
- Medicaid or FAMIS eligible or meet program income eligibility guidelines.
- Resident of Virginia.
- Last trimester of pregnancy, or provided for children seven (7) years old or younger who fit within the program safety seat manufacturer's guidelines.
- Available to attend a safety seat installation and use class.
- Sign a waiver of liability release form.

Foster parents can learn how to apply for the program or obtain technical assistance on child protection at their [local distribution site](#). For more information, contact the [Office of Family Health Services](#) in the Virginia Department of Health either online or at 1-800-732-8333.

Child-restraint devices for LDSS use may be purchased from administrative funds. Payment for devices to be used by foster parents may be purchased from administrative funds.

12.10.3 services

Purchasing transportation

Transportation may be provided from State Pool Funds, Medicaid (title XIX), or title IV-E funds as follows:

12.10.3.1 Using Medicaid to purchase transportation

Transportation to obtain medical services for the child may be provided through the child's Managed Care Organization (MCO). Transportation to the nearest provider capable of rendering care for covered services is covered by Medicaid when no other transportation is available. Logisticare is one Medicaid transportation service provider which coordinates drivers to transport members from their medical appointments anywhere in Virginia. This and other transportation services are accessed through the child's MCO. Additional information about covered transportation services and limitations can be found in the [Transportation Manual](#) of the Department of Medical Assistance Services.

12.10.3.2 Using title IV-E funds for transportation

Title IV-E funds shall be used to pay for transportation costs for title IV-E eligible children when transportation is needed for two distinct purposes described below. These payments are made in addition to the basic maintenance payments.

- Transporting the child to visits with either parents or siblings.

Title IV-E funds cannot be used for parents to travel to visit children. Reasonable costs of travel for a child to visit siblings, parents, and prior custodians to whom the child is expected to return may be made if needed. Costs may include mileage (calculated at the state mileage reimbursement rate), bus tickets, or other transportation costs. Providers shall submit receipts for travel costs to the LDSS in order to receive reimbursement.

- Transporting the child to remain in the school in which the child was enrolled prior to entry into foster care or prior to placement change.

Reimbursement of transportation costs may be made to foster parents, friends, relatives, neighbors, and employees of child placing agencies and residential programs. Public transportation, such as bus fare or other similar transportation, is paid at the established rate. Providers shall submit receipts for travel costs to LDSS in order to receive reimbursement. The LDSS may reimburse the local school district's school bus transportation fund. There shall be a documented agreement or contract between the LDSS and the local education agency (LEA) or

the company that manages the school bus system and a copy placed in the child's file. All travel costs require receipts and/or other documentation as determined by the LDSS. The LDSS shall maintain these receipts/documents per foster care record retention. Reasonable and necessary transportation costs shall be defined as those costs that are equivalent to the state/ federal mileage reimbursement rate. For those situations where the LDSS must negotiate a higher rate, the LDSS should have documentation to support why this is needed to meet the child's needs for school transportation. (For example: flat rates such as \$70 per day without a breakdown of the costs is unacceptable.) Federal language does not define reasonable or set maximum rates, however, monthly amounts that exceed the child's maintenance rate would require justification. Approval of transporters other than foster parents is at the discretion of the LDSS utilizing the local approval standards for this practice. It is the service worker's responsibility to review and approve the transportation costs then provide the supporting documentation (negotiated rate and justification) to the eligibility worker to determine eligibility for title IV-E funds.

For more information on funding transportation costs, see [Section 12.12](#).

Information on funding to support transportation expenses as part of maintenance costs is available in the [Finance Guidelines Manual](#), Section 4.25, LASER Budget Line and Cost Code Descriptions, 811.

12.10.3.3 Using State Pool Funds to purchase transportation

Transportation expenses for a non-title IV-E eligible child to remain in the school in which he or she was enrolled at the time of an initial or change in foster care placement are allowable maintenance costs and shall be purchased from State Pool Funds according to the criteria described in [Section 12.12](#). These payments are made in addition to the basic maintenance payments paid on behalf of the child. The LDSS and school shall have jointly determined that remaining in the same school is in the child's best interests.

State pool funds are not used for the transportation of foster care child or youth who require "specialized" transportation for purposes of special education, i.e. for children or youth who attend private day schools, or children or youth who have transportation accommodations noted within the IEP (require lift bus, special supervision, special restraints, etc). The local school division is responsible for "specialized" transportation.

Transportation purchased with state pool funds must meet all federal and state requirements for the provision of transportation for children and youth in foster care. The appropriate use of state pool funds for transportation of non title IV-E foster care children and youth is determined according to the same

requirements established for use of title IV-E funds for the title IV-E eligible child or youth.

Payment may be made to specific providers as follows:

- Foster parents and employees of child placing agencies and residential facilities using their own cars to transport an eligible child to visitation, to school, or to a visit with parents or siblings are paid at the state mileage rate for actual miles driven. Individual providers shall have a valid driver's license and automobile insurance and shall submit proof of miles driven to the LDSS for reimbursement.
- Public transportation paid at the established rate.
- Friends, relatives, and neighbors of the child or foster parent are paid at the state mileage rate. They shall have a valid driver's license and automobile insurance and shall submit proof of miles driven to the LDSS for reimbursement.

12.11 Health and behavioral health care services

Improving outcomes for children in foster care requires addressing the social and emotional well-being needs of children, including addressing their:

- Maltreatment, trauma, and/or exposure to violence needs.
- Health needs (developmental, physical, medical, and dental needs).
- Behavioral health needs (needs related to mental health & substance use disorders).⁶

12.11.1 Consent for medical treatment for children in custody

Where possible, parent(s) of a child who is committed or entrusted to an LDSS should always be involved in the medical planning for the child. When parent(s) are not available, or their consent cannot be obtained immediately, a court order is required for major medical/surgery treatment. If the court order is not readily available, the LDSS director or his designee may consent (§§ [16.1-241](#) and [54.1-2969 A.2](#)). A judge may give blanket authority to the LDSS to give consent. Such blanket authority should be in writing and signed by the judge. Any authorized person who consents to medical/surgical treatment of the child shall make a reasonable effort to notify parent(s)/guardians as soon as possible. Foster parents, adoptive parents prior to the final order, and residential facilities can obtain routine or minor medical care for the child.

⁶ [*Information Memorandum: Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services*](#) (ACYF-CB-IM-12-04; April 17, 2012).

12.11.1.1 Consent for medical treatment for children placed in foster care through non-custodial agreements when parent(s) retain custody

Parent(s) or guardians of children in non-custodial foster care placements shall provide consent for medical treatment, except in those instances where consent has been delegated to the LDSS in the non-custodial foster care agreement.

12.11.1.2 When a minor may consent to medical and health services

A minor's consent is needed to:

- Determine the presence or treatment of venereal disease or any infections or contagious disease reportable to the state health department.
- Receive service for birth control, pregnancy, family planning, and out-patient care.
- Receive services for treatment or rehabilitation for substance use disorders, mental illness, or emotional disturbance ([§ 54.1-2969 E](#)).

12.11.1.3 Authority of permanent foster parents to give consent for medical care

The foster parent of a child in a court-approved Permanent Foster Care placement has the right to consent to surgery unless the court order for placement has modified this right ([§ 63.2-908](#)).

12.11.1.4 Consent for treatment for young adults in foster care

Upon reaching the age of 18, the former foster child is an adult and is responsible for consenting to his/her own medical treatment. The young adult should designate someone to make health care treatment decisions on his/her behalf, if the young adult becomes unable to participate in the decisions and does not have or want a relative who would otherwise be authorized by State law to make these decisions. The young adult, after reaching age 18, may designate a health care power of attorney by completing the form, entitled [Virginia Advance Medical Directive](#), on the Virginia Department of Health (VDH) website, which complies with Virginia law ([Patient Protection and Affordable Care Act P.L. 111-148; § 54.1-2995](#)). The LDSS should encourage and assist the youth in seeking guidance from an attorney to address any questions he/she has. The young adult should provide a copy of this document to his/her physician, and close relatives and/or friends.

12.11.1.5 Consent for psychotropic medication

Except in those instances noted in [Sections 12.11.1.1](#) through [12.11.1.4](#), the local department has authority to give informed consent for psychotropic medication for a child in the care of the local department. In order to grant consent for a child to take psychotropic medication, the local department is required to identify a Psychotropic Medication Consenter (PMC). Approved PMCs review the prescription for the medication, gather the necessary information, and make a decision to provide or to deny consent. PMCs are required to complete additional training as outlined in [Section 12.11.8](#). When selecting an individual to serve as a PMC, agencies should select someone who has the experience and knowledge to effectively advocate for the child.

12.11.2 Medical care and treatment to be provided to child in foster care

The service worker shall ensure the child receives:

- A medical evaluation **within 72 hours** of initial placement in foster care, when the child has conditions that indicate such an evaluation is necessary ([22 VAC 40-201-50 C](#)). When the child has urgent health, mental health, or substance use needs upon entering foster care, the service worker shall immediately refer the child to a licensed health or mental health professional for an appropriate evaluation to be completed within 72 hours.
- A medical examination **no later than 30 days** after initial placement in foster care ([22 VAC 40-201-50 C](#)). The provider should be a Medicaid provider for the Medicaid eligible child or a provider covered by the child's health insurance.
- Periodic screenings (well-child visits) at regular intervals based on Virginia's EPSDT periodicity schedule. The child shall receive well-child visits while in foster care, including:
 - At birth, at age 3-5 days, and by 1 month of age.
 - At age 2 months, 4 months, 6 months, and 9 months.
 - At age 12 months, 15 months, 18 months, 24 months, and 30 months.
 - Annually at age 3 years up to 18 years.

The Virginia Department of Medical Assistance Services (DMAS) uses the American Academy of Pediatrics and Bright Futures guidelines to develop the schedule. See:

- Well Child Visit Schedule, see [EPSDT Periodicity Chart](#).

- [American Academy of Pediatrics \(AAP\) Recommendations for Preventive Pediatric Health Care.](#)
- [American Committee on Immunization Practices \(ACIP\) Child & Adolescent Immunization Schedules.](#)
- Inter-periodic screenings when any caregiver or professional who interacts with the child requests an unscheduled check-up or problem focused assessment at anytime because of illness or change in the child's condition while in foster care.
 - When it appears the child may have trauma, mental health, or substance use issues, as identified through the medical examination or comprehensive assessment conducted within the first thirty (30) days of entering foster care, the child shall receive a comprehensive mental health evaluation with a licensed mental health professional **within 60 days** of entering foster care.

Medical care shall be provided for the child who is ill or injured and ongoing medical treatment for the child with physical, mental, or emotional needs.

- Dental examinations while the child is in foster care **beginning at whichever is later, six (6) months of age or when the child gets teeth and every six (6) months** thereafter. This schedule is based on guidelines by the American Academy of Pediatric Dentistry, the American Dental Association, and the American Academy of Periodontology. For Medicaid enrolled children, this schedule is in accordance with DMAS' Smiles for Children Program.
 - See Dental Visit Schedule, see [Dental Health Guidelines](#).

Prior to the child being placed on a new psychotropic medication, the child should receive the following inter-periodic screens/assessments:

- A pediatric medical examination to ensure symptoms are not indicative of a medical problem, except in the case of an emergency. In an emergency, a physical examination should be conducted as soon as possible.
- A comprehensive child and adolescent behavioral health evaluation by a licensed mental health professional to identify psychosocial interventions.

Note: When the child's condition has already been evaluated and the doctor is changing treatment or psychotropic medication after a treatment or psychotropic medication did not work, these examinations are not necessary (see [Section 12.11.8.2](#)).

Medical examinations are provided in accordance with the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, whether or not the child has Medicaid

coverage. EPSDT is a comprehensive and preventive child health program for individuals under age 21 through the Medicaid program (see [Section 5.9.3](#)).

The service worker should involve the birth parents in attending the child's medical appointments when appropriate. Participating in these visits helps educate the birth parents on the child's needs and health care and helps provide continuity of care when the child returns home.

The service worker shall document on the Health Information Screens in OASIS and the foster care paper case record that the medical and dental examinations were obtained for the child as required. Documentation shall include the date, type of examination, name and address of health care provider, results, and any follow-up instructions. Bright Futures resources on children's health information

The service worker should inform the child's birth parent or guardian, family members, foster care provider, and/or caregiver of Bright Futures resources that provide comprehensive information and guidelines on children's health.

- Bright Futures is the American Academy of Pediatrics' standard reference book on children's health information for pediatricians. It is a set of principles, strategies and tools that are theory-based, evidence-driven and systems oriented that can be used to improve the health and well-being of children. It provides a comprehensive set of expert guidelines, as well as a practical developmental approach to providing health supervision for children from birth to age 21 in the context of family and community. The guidelines are designed to present a single standard of care and a common language based on a model of health promotion and disease prevention.
 - [American Academy of Pediatrics website on Bright Futures](#).
 - For information about Virginia's Bright Futures, see the [Virginia Department of Health website](#).
 - The [Healthy Futures website](#) is an online version of Bright Futures designed for parents and caregivers of all children, from newborns to older teens. It shares children's health information from Bright Futures through short videos and text. Parents and caregivers can use this website to learn about what to expect at routine doctor's visits, child development milestones, and specific topics like nutrition and mental health. They can also learn how to be active participants in promoting a child's health and well-being.

12.11.3 Trauma focused treatments

Complex trauma affects a child's sense of safety, ability to regulate emotions, and capacity to relate well to others. Since complex trauma often occurs in the context of the child's relationship with a caregiver, it interferes with the child's ability to form a

secure attachment. Consequently, an important goal of service delivery is to help children and youth develop positive social emotional functioning, restore appropriate developmental functioning, and reestablish healthy relationships.⁷

Trauma-informed care redirects attention from treating symptoms of trauma (e.g., behavioral problems, mental health conditions) to treating the underlying causes and context of trauma. Trauma-specific interventions include medical, physiological, psychological, and psychosocial therapies provided by a trained professional that assist in the recovery process from traumatic events. Treatments are designed to maximize a child's sense of physical and psychological safety, develop coping strategies, and increase a child's resilience.⁸

Examples of evidence-based therapies for trauma include:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS).
- Parent-Child Interactive Therapy (PCIT).
- Child-Parent Psychotherapy (CPP).
- Dialectical behavioral therapy (DBT).
- Trauma and Grief Component Therapy for Adolescents (TGC T-A).

Examples of other types of therapy used with trauma include:

- Behavioral therapy.
- Play therapy.
- Group therapy.
- Parent coaching.

For resources to address trauma, see:

⁷ Excepted from the [Tri-Agency Letter on Trauma Informed Treatment](#) dated July 11, 2012 from the United States Department of Health and Human Services' Administration for Children and Families (ACF), Centers for Medicare & Medicaid Services (CMS), and Substance Abuse and Mental Health Services Administration (SAMHSA).

⁸ Information in this section excepted and adapted from [Implementing Trauma-Informed Practices in Child Welfare](#). Klain, Eva J. White, Amanda R. State Policy Advocacy and Reform Center (SPARC). First Focus. American Bar Association Center on Children and the Law. 2013.

- The [National Child Traumatic Stress Network](#) and the [National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices](#).
- SAMSHA's [National Registry of Evidence-based Programs and Practices \(NREPP\)](#) searchable online registry of mental health and substance interventions available for implementation.
- National Institute of Justice: [Children Exposed to Violence](#).

Providing trauma-specific interventions is one component of serving children who have experienced traumatic stress. The LDSS and child-serving systems need to collaborate in instituting trauma-informed practices. All stakeholders (e.g., the child, parents, caregivers, service workers, supervisors, administrators, service providers, judges, attorneys) should be involved in recognizing and responding to the impact of traumatic stress on children and their caregivers. They should all be involved in helping to facilitate resiliency and recovery.

12.11.4 Children with Special Health Care Needs Program

The [Children with Special Health Care Needs \(CSHCN\) Program](#) by the Virginia Department of Health promotes optimal health and development of Virginia's children with special health care needs by working in partnership with families, service providers, and communities.

- [Care Connection for Children](#) is a statewide network of Centers of Excellence for children with special health care needs. The [centers](#) provide access to specialty medical services; assistance coordinating care and services; assistance in obtaining health insurance for the child; information and referral to community resources; family-to-family support; and training and consultation with community providers.
- [Child Development Services Program](#) is a specialized program for children and adolescents who are suspected of having developmental and behavioral disorders. A professional team, with a pediatrician, nurse, social worker, educational consultant, and psychologist, provides services. Core services of the [child development clinics](#) include diagnostic assessment and care planning, follow-up care coordination and referral.

12.11.5 Paying for medical care

For the Medicaid eligible child, Medicaid may be used to pay for medical needs including transportation to the Medicaid provider when other transportation is not available.

Other funding can only be used to pay for medical needs not covered under Medicaid, or medical services provided by vendors or in facilities not covered by

Medicaid under fee-for-service or the responsible managed care organization (MCO). (Note: Medicaid will pay for providers that are in the MCO provider network that are not in the DMAS Medicaid provider network.) The foster care provider or service worker should ask the medical provider to verify eligibility prior to services being provided to ensure coverage of services.

Resources for costs of medical care not covered by Medicaid include:

- Child's own income or resources including parents' health insurance and SSI/SSA.
- General relief.
- State pool funds (CSA).

12.11.6 Medicaid services

The [Medicaid Program](#) is managed by the Virginia Department of Medical Assistance Services (DMAS). Medicaid services most related to children and youth in foster care are identified in this section; not all Medicaid services are listed. For a complete listing and description of covered and non-covered services, see the [Medical Assistance for Families and Children Handbook](#).

12.11.6.1 Medicaid eligibility

Children in foster care placement are eligible for Medicaid unless they are not considered Virginia residents, or they have income or other financial resources that make them ineligible for Medicaid.

12.11.6.1.1 Medicaid eligibility under age 26 for children in foster care

Effective January 1, 2014, the young adult who was formerly in foster care in Virginia (title IV-E and non-title IV-E eligible) may be eligible to receive Medicaid up to age 26. Effective July 1, 2014, former foster care youth from other states may also be eligible for Virginia Medicaid up to age 26. Youth must meet the following four (4) requirements. The youth:

- Was under the care and responsibility of any state's foster care agency.
- Was receiving Medicaid until his discharge from foster care upon turning 18 years or older.
- Is not eligible for Medicaid in another mandatory Medicaid covered group; and

- Is under age 26 years.

The young adult does not need to meet financial eligibility requirements. However, the young adult must meet all other Medicaid requirements. An application is not required, unless the youth is no longer receiving Medicaid through foster care or was a former foster care youth from another state. Former foster care status will be verified with documentation by the young adult, agency records, or contact with the LDSS that held custody.

The service worker should provide notification to the benefits program specialist to perform a partial review of eligibility for a youth who is turning 18, is a Virginia resident, and meets eligibility requirements stated above.

The youth's transition plan should address any services related to his/her health care needs including insurance coverage and coordination with the benefits program specialist during the course of the youth's transition out of foster care (see [Section 13.14](#)).

If the eligible youth was:

- In foster care and enrolled in Medicaid during the month foster care ended, the youth is entitled to Medicaid coverage beginning the first day of the month following the month the child was no longer in foster care.
- If the eligible youth was a former foster care youth and Medicaid was previously discontinued when the youth turned 18, the youth may reapply for coverage and be eligible in this covered group when meeting eligibility requirements.

12.11.6.1.2 Residency requirements for Medicaid

Per federal guidance, the SSI eligible child is considered a resident of the state in which he is living. Being a non-title IV-E child does not negate eligibility to receive Medicaid in Virginia. The SSI eligible child is eligible for Medicaid and is not required to meet the Virginia Medicaid residency requirement. Additional residency clarification is listed below:

- A IV-E foster care child receiving a maintenance payment is a resident of the state in which he is living.
- A IV-E adoption assistance child is a resident of the state in which he is living whether or not a maintenance payment is being made.
- An SSI child is a resident of the state in which he is living.

- A non-IV-E foster care child who is not an SSI recipient is a resident of state which holds his custody.

12.11.6.1.3 Medicaid out-of-state

If a title IV-E child is placed out-of-state, information certifying the child's title IV-E status shall be sent to the Interstate Placement Unit in Home Office so that it may be sent to the receiving state. Title IV-E foster children and children receiving title IV-E adoption subsidy are eligible for Medicaid coverage in the state where they reside.

Non-title IV-E children placed out-of-state meet the Virginia residency requirement and may be eligible for Virginia Medicaid; however, providers in other states often do not accept Virginia's Medicaid coverage, and the LDSS will have to pay for uncovered medical expenses out of State Pool Funds.

The non-title IV-E child may or may not receive Medicaid under the receiving state's Medicaid Program. Before a child is placed, the caregiver should consult their local public assistance office to determine whether the child will be eligible to receive medical coverage in the receiving state.

If the child is not eligible to receive Medicaid coverage in the receiving state, the child will continue to be covered under Virginia Medicaid. In this case, medical service providers in the other state will need to register as Virginia Medical providers in order to bill Virginia for services provided to the child. **Prior** to placement, the caregiver should be instructed to find medical service providers who are willing to register as Virginia providers and willing to accept Virginia payment rates. Out of state medical providers should log onto <http://dmas.virginia.gov/> to enroll as Virginia providers.

12.11.6.1.4 Extension of Medicaid for children in adoptive placement

Medical coverage is extended during the adoptive placement until the final order of adoption for children who continue to meet the foster care covered group for Medicaid purposes.

When placing non-title IV-E eligible children for adoption, it is best to have Adoption Assistance in place prior to placement, if possible. In many states, children will be eligible for medical coverage if adoption assistance is in place.

Medical coverage is extended past the final order if:

- The child is title IV-E eligible with a subsidized adoption assistance agreement in effect, regardless of the existence of an interlocutory order or final judicial decree; or
- The adoptive family meets the financial requirements of Medicaid; or
- The child is non-title IV-E eligible, but has special medical or rehabilitative needs referenced in an adoption assistance agreement and meets the financial requirements for the Child Under Age 21 covered group as determined by Virginia's Medicaid program.

12.11.6.2 Using Medicaid providers

Medicaid providers shall be used for the Medicaid eligible child whenever they are available and accessible for the appropriate treatment of children and youth under fee-for-service. For the Medicaid eligible child receiving services under a responsible managed care organization (MCO), providers in that MCO provider network shall be used. (Note: Medicaid will pay for providers in the MCO provider network that are not in the DMAS Medicaid provider network.) The foster care provider or service worker should ask the service provider to verify eligibility prior to services being provided to ensure coverage of services.

State pool funds shall not be spent for any service that can be funded through Medicaid for Medicaid-eligible children and youth except when Medicaid funded services are unavailable or inappropriate for meeting the needs of a child. ([Appropriation Act Item 274E](#))

The needs of the child and family shall take precedence over the use of Medicaid-funded services. For example, a child should not be placed in a group home far away from his or her home just to use a Medicaid facility. Similarly, a child should not be placed in a higher level of care than necessary just to access Medicaid funding.

12.11.6.3 Medicaid's Early Intervention Program

Services under Medicaid's Early Intervention Program include:

- Case management and service coordination.
- Developmental services.
- Family training.
- Counseling.
- Speech-language pathology, including sign language and cued language services.

- Nursing services.
- Occupational therapy.
- Physical therapy.
- Psychological services.
- Social work services.
- Assistive technology related services (such as instruction or training on use of assistive technology).

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

[EPSDT](#) is a comprehensive and preventive child health program for children in Medicaid or FAMIS Plus up to the age of 21 that detects and treats health care problems early through:

- Regular medical, dental, vision, and hearing check-ups. See [Section 5.9.3.1](#) on when EPSDT screenings shall be provided for child.
- Diagnosis of problems.
- Treatment of dental, eye, hearing, and other medical problems discovered during check-ups.
- Specialized services that are medically necessary treatment services that are not a routinely covered service through Virginia Medicaid. All such services must be a service that is allowed by the Centers for Medicare and Medicaid Services (CMS), as defined in 42. U.S.C. sec 1396d (r) (5).
- Examples of EPSDT specialized services include:
 - Hearing and audiology.
 - Assistive technology devices.
 - Behavioral therapy and applied behavior analysis services
 - Personal care.
 - Private duty nursing.
 - Medical infant formula and medically necessary nutritional supplements.

- See the (DMAS) website on the [EPSDT program](#) for information on specialized services, including:
 - An overview to EPSDT Specialized Services.
 - EPSDT Fact Sheets on specific services.
 - Information and forms for service authorization.

All EPSDT treatment services must:

- Be deemed medically necessary to correct or ameliorate a health or mental health condition.
- Be documented by a physician when the need is for specialist referral or treatment.
- Not be services that are considered experimental or investigational.

EPSDT services do not require a local match.

For more information on EPSDT services, see the EPSPT manual under [Provider Manuals](#) on the DMAS Web Portal link at www.virginiamedicaid.dmas.gov. The following chapters may be most helpful: Chapter 2 - Provider requirements; Chapter 4 - Covered services; and Chapter 6 - Documentation requirements.

12.11.6.5 Dental services

The Smiles For Children program provides coverage for diagnostic, preventive, and restorative/surgical procedures, as well as orthodontia services for children. DentaQuest is the single dental benefits administrator that will coordinate the delivery of all Smiles For Children dental services. Dental services do not require a local match.

For more information on dental services, see

- [Dental services](#)
- [Dentists who accept Medicaid](#)
- Dental Services Manual under [Provider Manuals](#) on the DMAS Web Portal link at www.virginiamedicaid.dmas.gov. The following chapters may be most helpful: Chapter 2 - Provider requirements; Chapter 4 - Covered services; and Chapter 6 - Documentation requirements.

12.11.6.6 Community Mental Health Rehabilitation Services

Medicaid provides coverage for community mental health rehabilitation services. These services are provided in the child's home or community and provide diagnosis, treatment, or care of children with mental illnesses or intellectual disability. Services shall meet service definitions, eligibility criteria, required activities, and service limitations. Providers of services shall meet qualifications specified under the "Provider Participation Requirements."

Service authorization is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid-enrolled provider prior to service delivery and reimbursement. Some services do not require service authorization and some require service registration.

Registering a service with Magellan as the service is being provided ensures that the care coordinator has a complete picture of all the services an individual is receiving. Registration also may assist with identifying gaps in services that may help an individual progress in their recovery.

These services are managed by [Magellan](#). They are provided primarily by Community Services Boards and private providers:

- Crisis Intervention – requires registration.
- Crisis Stabilization – requires registration.
- Mental Health Support Services - requires authorization.
- Intensive In-Home Services for Children and Adolescents - requires authorization.
- Therapeutic Day Treatment for Children and Adolescents - requires authorization.
- Community-Based Residential Services for Children and Adolescents under 21 - Level A.
- Therapeutic Behavioral Services for Children and Adolescents - Level B - requires authorization.
- Services for older youth approved on case by case basis:
 - Day Treatment/Partial Hospitalization - requires authorization.
 - Psychosocial Rehabilitation - requires authorization.
 - Intensive Community Treatment - requires authorization.

- Mental Health Targeted Case Management - requires registration.

For more information, see the Community Mental Health Rehabilitation Services Manual under [Provider Manuals](#) on the DMAS Web Portal link at <http://dmasva.dmas.virginia.gov/>. The following chapters may be most helpful: Chapter 2 - Provider requirements; Chapter 4 - Covered services; and Chapter 6 - Documentation requirements.

12.11.6.7 Medicaid's Addiction and Recovery Treatment Services (ARTS) program

Medicaid's Addiction and Recovery Treatment Services (ARTS) program provides a wide variety of services and treatment for individuals with substance use disorders, including inpatient, outpatient, opioid treatment programs, early intervention/screening, substance use case management, and residential services. Additionally, crisis intervention is covered for both substance use disorder and/or mental health crises through the Community Mental Health Rehabilitation Services (See Section 12.11.7.6). For more information, see the Addiction and Recovery Treatment Services (ARTS) program manual under [Provider Manuals](#) on the DMAS Web Portal link at <http://dmasva.dmas.virginia.gov/>. The following chapters may be most helpful: Chapter 2 - Provider requirements; Chapter 4 - Covered services; and Chapter 6 - Documentation requirements.

12.11.6.8 Medicaid Psychiatric Services

- Outpatient Psychiatric Services - Individual therapy, family therapy, or group therapy.
- Inpatient Acute Psychiatric Services (Acute Hospital and Acute Freestanding Hospitals – requires authorization.
- Psychiatric Residential Treatment Facility Level C – requires authorization.
- Treatment Foster Care Case Management – requires authorization

For more information, see the Psychiatric Services Manual under [Provider Manuals](#) on the DMAS Web Portal link at [The Department of Medical Assistance Services/Medicaid for Virginia](#). The following chapters may be most helpful: Chapter 2 - Provider requirements; Chapter 4 - Covered services; and Chapter 6 - Documentation requirements.

12.11.6.9 Medicaid Rehabilitation Services

- Intensive Rehabilitation Services include:

- Physician.
- Rehabilitative Nursing
- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology
- Cognitive Rehabilitation Therapy
- Psychology
- Social Work
- Therapeutic Recreation
- Prosthetic/Orthotic Services
- Durable Medical Equipment
- Outpatient Rehabilitation Services

For more information, see the Rehabilitation Services Manual under [Provider Manuals](#) on the DMAS Web Portal link at [The Department of Medical Assistance Services, Medicaid for Virginia](#). The following chapters may be most helpful: Chapter 2 - Provider requirements; Chapter 4 - Covered services; and Chapter 6 - Documentation requirements.

12.11.6.10 Medicaid Durable Medical Equipment

- Listing of covered supplies can be found in the “Appendix B” documents under [Provider Manuals](#) on the DMAS Web Portal link at <http://dmasva.dmas.virginia.gov/>.
- Wheelchairs.
- Communication devices.
- Diabetic supplies.
- Incontinence supplies.

12.11.6.11 Medicaid Long-Term Care Services

Medicaid pays for long-term care services in some institutional settings, such as in nursing facilities and Intermediate Care Facilities, and in communities through Home and Community Based Care Waivers.

Medicaid Waivers provide funds to serve people who are eligible for long-term care in institutions, such as hospitals, nursing facilities, and intermediate care facilities. Through Medicaid Waivers, certain requirements are “waived,” including the requirement that individuals live in institutions in order to receive Medicaid funding. Waiver services do not require a local match.

The service worker shall notify the appropriate community services board as soon as it is known that a child in foster care has a developmental disability so that the community services board may screen the child for placement on the developmental disability waiver waiting list ([2019 Acts of Assembly Chapter 301](#)). It is imperative that children are placed on this waiting list as soon as possible so that they are able to receive services offered through the waiver more quickly. Additionally, these services can be beneficial in supporting the child’s family and caregivers after discharge from foster care and providing services to youth who are transitioning to adulthood.

Children may be eligible for the following waivers:

- Intellectual Disabilities (ID) Waiver.
 - Eligibility: An individual shall be age 6 or older and have a diagnosis of ID or be under age 6 and at developmental risk. The person should be eligible for placement in an intermediate-care facility for persons with intellectual disabilities or other related conditions (ICF-ID).
 - Services available: Residential support services, day support, supported employment, prevocational services, personal assistance (agency and consumer directed), respite (agency and consumer directed), companion services (agency and consumer directed), assistive technology, environmental modifications, skilled nursing services, therapeutic consultation, crisis stabilization, transitional services, and personal emergency response systems (PERS). Support coordination is also provided.
 - Visit the [Department of Behavioral Health and Developmental Services \(DBHDS\)](#) website for additional information on this waiver.
- Individual and Family Developmental Disabilities Support (IFDDS or DD) Waiver.

- Eligibility: The DD Waiver provides services to individuals 6 years of age and older who have a diagnosis of a developmental disability and do not have a diagnosis of intellectual disability. Individuals also should require the level of care provided in an intermediate-care facility for persons with intellectual disability or other related conditions (ICF/MR). Children who do not have a diagnosis of intellectual disability, and have received services through the ID Waiver, become ineligible for the ID Waiver when they reach the age of 6. At that time, they can be screened for eligibility for the DD Waiver; if found eligible they will receive a DD waiver slot without being placed on the DD waiver waiting list.
- Services available: Day support, companion services (agency and consumer directed), supported employment, in-home residential support, therapeutic consultation, personal care services (agency and consumer directed), respite care (agency and consumer directed), skilled nursing services, attendant services, family and caregiver training, crisis stabilization, environmental modifications, assistive technology, personal emergency response system (PERS), and prevocational services. Case management is also provided.
- Contact the [Department of Behavioral Health and Developmental Services \(DBHDS\)](#) for additional information on this waiver.
- Elderly or Disabled with Consumer Direction (EDCD) Waiver
 - Eligibility: This waiver serves the elderly and persons of all ages with disabilities. An individual must meet nursing facility eligibility criteria, including both medical needs and functional capacity needs (assistance with activities of daily living). An individual can remain on the waiting list for another waiver while being served by the EDCD Waiver and then transfer to the preferred waiver once a slot becomes available.
 - Services available: Personal care aide services, adult day health care, respite care, skilled respite care, personal emergency response system (PERS), and medication monitoring.

For more information on these and other waivers, see the DMAS Guide on [“Virginia’s Medicaid Waivers for Persons with Disabilities, Their Parents, and Caregivers.”](#)

Waivers are funded per “slot.” A slot is an opening of waiver services available to a single individual. For some waivers, there are waiting lists of persons who have already applied or who have been assessed as eligible and are still waiting to receive a waiver slot. It is important to put the child on the waiting list

as early as possible, even if no slots are currently available. Waiting lists also help document the unmet need for services when funding priorities are decided.

Receiving a waiver slot also does not guarantee that a child or youth will be able to access services included in the waiver. Services can be provided only by approved agencies in each locality. There may be a limited number of approved persons or agencies in a particular area.

12.11.7 Preventing misdiagnosis of children in foster care

When children in foster care are given a diagnosis it is important to ensure that the diagnosis is accurate and that any diagnoses made are periodically reviewed for continued accuracy. To ensure accurate diagnosis, the service worker should:

- Involve the child, parents or guardians, and caregivers in assessments and appointments with professionals treating the child.
- Arrange for the child to have a medical examination prior to the child receiving mental health treatment and/or being given a mental health diagnosis to ensure symptoms are not indicative of a medical problem.
- Arrange for a comprehensive child and adolescent mental health evaluation by a licensed mental health professional. Request that the evaluation address:
 - The child's previous diagnosis (if applicable)
 - Psychosocial supports and/or behavioral health services to help meet the child's needs, build on the child's strengths, and help create resiliency in the family, as appropriate.
 - The appropriate sequencing of psychosocial and/or pharmacologic interventions.
- Help prepare the child and family members, as appropriate, for doctor visits, including how they might:
 - Share information on the child's emotions, behavior, and symptoms with the doctor.
 - Ask questions about the child's medication and treatment.
 - Seek a second opinion, if necessary.
- Ensure that the providers working with the child, including caregivers, are trained to recognize trauma symptoms and are able to provide trauma informed care.

- Keep the child's team informed of the child's mood and behaviors as one component of the overall foster care plan for the child and the family.

For additional information regarding mental health diagnosis and treatment for children see:

- American Academy of Child and Adolescent Psychiatry, Family Resources: https://www.aacap.org/AACAP/Families_and_Youth/Family_Resources/Home.aspx
- Find Youth Info, Youth Mental Health website at: <https://youth.gov/youth-topics/youth-mental-health>
- National Institute of Mental Health, Publications about Children and Adolescents website at: <https://www.nimh.nih.gov/health/publications/children-and-adolescents-listing.shtml>

12.11.8 Psychotropic Medication Oversight Protocol

For some children in foster care who have complex mental health needs, psychotropic medications can be one important component of comprehensive care. There has been a steady increase nationally in the use of psychotropic medications to address the emotional and behavioral problems of children in foster care over the past decade. Data reported from empirical studies show that children in foster care:

- Have higher rates of psychotropic medication use compared to other children in Medicaid and in the general population.
- Are more likely to be prescribed psychotropic medications as they age.
- Often receive more than one class of psychotropic medications when they take such medications.
- Are most likely to receive psychotropic medications in the most restrictive placements, such as group homes or residential treatment programs.

Children in foster care have disproportionately high rates of emotional, behavioral, and mental health needs that require intervention. They also use disproportionately more behavioral health services. Therefore, the higher use of psychotropic medications may in part reflect the increased emotional and behavioral distress for children in foster care.

However, the dramatic increase in use of psychotropic medications may at times exceed clinical practice standards supported by empirical research. There are concerns that when children in foster care are prescribed too many or too much psychotropic medication or prescribed medications when they are too young. There are also significant geographic variations within and across states in the prevalence

of psychotropic use. While some children in foster care may be prescribed too many medications, others may not have access to needed medications.⁹

12.11.8.1 Responsibilities of service worker in managing child's medications

The service worker is responsible for ensuring that psychotropic medications are documented in OASIS (using the health information screen) and administered and monitored for the child in foster care, including:

- Involving the child, parents or guardians, and caregivers in ongoing decision-making as appropriate, including obtaining appropriate consents (See [Section 12.11.1](#)).
- Encouraging the foster parent, TFC worker, or other caregiver to communicate with the MCO about the child's needs and any services or resources the MCO can provide to assist the child.
- Keeping the child's team informed of the child's psychotropic medications as one component of the overall foster care plan for the child and family.
- Ensuring that each child prescribed psychotropic medications is receiving and participating in all recommended behavioral health services (i.e. non-pharmacological interventions).
- Arranging for the child to have the examinations outlined in [Section 12.11.8.1](#).
- Identifying the specific individual where the child is living who is responsible for the management, administration, and monitoring of the child's medications.
- Helping prepare the child and family members, as appropriate, for doctor visits, including:
 - Sharing information on the child's emotions, behavior, and symptoms with the doctor.
 - Asking questions about the child's medication and treatment.
- Ensuring caregivers and providers are informed about the child's medication. Sources of information for caregivers and providers include:

⁹ Excerpted and adapted from [Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care](#) (ACYF-CB-IM-12-03; April 11, 2012).

- The drug information provided by the doctor or pharmacist.
- Any black box warning labels with potential adverse effects placed on the prescription medication by the Food and Drug Administration (FDA).
- The [Medication Guide](#) for the specific medication on the FDA website. These guides are the paper handouts included with many prescription medicines. They address issues specific to particular drugs and drug classes, and they contain FDA-approved information that can help patients avoid serious adverse events.
- Calling the doctor's office or pharmacist with any questions or concerns.
- Ensuring that a written plan is developed and implemented for administering and monitoring each of the child's medications. The medication plan should include:
 - The name, addresses, and contact information of the doctor prescribing the medication.
 - The name of the medication.
 - The purpose of the medication.
 - The dose and how often the child should take the medication.
 - The maximum dose the child should take.
 - Whether the medicine should be taken with food or on an empty stomach.
 - Any foods, medications, or activities the child should avoid while taking the medication.
 - What to do if the child misses a dose.
 - When to change the dose, if applicable.
 - When to stop the medication and how to stop taking it.
 - Strategies to prevent or minimize side effects.
 - Dates of follow-up visits for tests and doctor appointments.

- When to call the doctor.
- The child's adherence to the medication regimen.
- All side effects the child experiences.
- Information on how the medication is working (e.g., child reports, family reports, teacher reports).
- Communicating to the child, family, foster care provider, other caregivers, and other significant individuals (e.g. teacher), as appropriate, the importance of:
 - The child adhering to the medication regimen prescribed by the doctor.
 - Monitoring the child's emotions, behavior, and symptoms.
 - Reporting any side effects and issues related to the medication.
- Discussing the child's medication with the child and caregivers during ongoing monthly visits, including:
 - How does the child feel about being on the medication?
 - Is the child taking the medication as prescribed? If not, what are the issues and how are they being resolved?
 - Have there been any changes in the child's behavior, mood, appetite, sleep, school performance, and relationship with others?
 - Is the child having any side effects? How are they being managed? Are these strategies working or not?
 - Has the child attended all medical appointments? What are the dates of upcoming appointments with the doctor?
- Arranging for the child to obtain all necessary tests and attend all medical appointments.
- Contacting the prescribing doctor when there are concerns about the medication. May also contact the pharmacist and the primary care provider. Should contact a child and adolescent psychiatrist when there are significant concerns.
- Reviewing how the child's medications are working and any concerns identified regarding continued use at every FPM held for the child and

ensuring the PMC has the Family Partnership Team's feedback to guide a review of the consent as outlined in [Section 12.11.8.3.5](#).

12.11.8.2 Assessment

Accurate assessment is essential to preventing barriers to least restrictive placements as outlined in [Section 12.11.7](#). Accurate assessments ensure that children in care are receiving the appropriate services and treatment targeted to their needs. An inappropriate diagnosis may delay them getting the services and treatment that they need, thus exacerbating or prolonging symptoms they may be experiencing. They may also be placed on medication that they will not benefit from and may cause significant side effects.

Prior to the child being placed on a new psychotropic medication, the child should receive the following inter-periodic screens/assessments:

- A pediatric medical examination to ensure symptoms are not indicative of a medical problem, except in the case of an emergency. In an emergency, a physical examination should be conducted as soon as possible.
- A comprehensive child and adolescent behavioral health evaluation by a licensed mental health professional to identify psychosocial interventions. Information should be requested on:
 - The child's diagnosis.
 - Psychosocial supports and/or behavioral health services to help meet the child's needs, build on the child's strengths, and help create resiliency in the family, as appropriate.
 - The appropriate sequencing of psychosocial and/or pharmacologic interventions.

Note: When the child's condition has already been evaluated and the doctor is changing treatment or psychotropic medication after a treatment or psychotropic medication did not work, these examinations are not necessary.

When children enter care with prescriptions for psychotropic medications, they are required to receive (as part of the evaluations required when a child enters care) a medical examination within 30 days of their placement into care and a mental health evaluation within 60 days of entering care ([Section 12.11.2](#)). These evaluations should address the same categories listed above and should be completed with input and collaboration from the child's current providers. Additionally, information should be gathered from the birth parents or prior custodian, the current caregiver, and the child about how the medication is

working and any side effects. Unless there is an immediate safety concern, the service worker can provide consent for the medication to continue until the next medication appointment. At that time, the PMC will review all available information and provide the consent for the medication to continue or change. This will allow time for the assessments to be completed to provide a more comprehensive understanding of the child's needs.

12.11.8.3 Interventions

Non-pharmacological interventions are any therapies or behavioral strategies that don't involve medicine that are designed to manage the child's behavior or symptoms. Non-pharmacological interventions should be considered prior to beginning a psychotropic medication, except in emergency situations when the child's safety or health is in immediate danger. Non-pharmacological interventions should begin before or concurrently with psychotropic medication.

Interventions should be trauma-informed and evidence-based whenever possible. Resource links are included in [Section 12.3](#) and [Section 12.11.3](#) to registries and databases of trauma-informed and/or evidence-based interventions.

The child's service providers, including the Primary Care Physician (PCP), should be involved in the decision-making process regarding use of psychotropic medication and their input should be considered as a member of the child's treatment team. Service providers should be informed of the medication the child is on and be part of the ongoing monitoring effort. As psychotropic medications can have significant impacts on the mental and physical health of the child, collaboration with the child's PCP and other service providers is essential. Additionally, care coordination should include the MCO efforts and resources. Coordinating care with the MCO will prevent duplication of effort and ensure that the child is getting the most comprehensive case management.

12.11.8.4 Informed consent

Except in the instances described in Sections [12.11.1.1](#) through [12.11.1.4](#), the local department shall give informed consent for psychotropic medication for a child in the care of the local department. In order to grant consent for a child to take psychotropic medication, the local department is required to identify a Psychotropic Medication Consenter (PMC). Approved PMCs review the prescription for the medication, gather the necessary information, and make a decision to provide or deny consent.

Informed consent is the process of receiving complete information about the proposed treatment or medical procedure (including risk, benefits, side effects) prior to making a decision. There are multiple components to informed consent, especially as it pertains to psychotropic medication.

In order to give informed consent, a PMC is required to have complete information on the proposed medication before making a decision. The PMC must understand:

- The child's diagnosis and symptoms,
- Details regarding the proposed medication (i.e. how that medication will help, how long the child might be taking it, procedures to follow, etc.),
- What may happen without the medication,
- The risks and benefits of the medication,
- Non-pharmacological interventions, which may be helpful,
- Side effects of the medication, and
- Why the doctor recommends the medication.

In addition to these elements, the PMC should also consider;

- Age of the child,
- Input from the child, family, and foster parents,
- Whether a second opinion is warranted, and
- Child and family medical history.

Approval of psychotropic medication for youth should always be made thoughtfully, considering all relevant information and involving the family and caregivers in the decision-making process. The family has historical information and valuable insight. By involving the family, this helps support the continuity of services when the child achieves permanency.

Informed consent may also be withdrawn at any time after consultation with the prescriber. If informed consent for a specific medication is being withdrawn, instructions regarding how to safely discontinue the medication should be gathered from the prescriber, provided to the caregiver, and documented in the child welfare information system.

12.11.8.4.1 Psychotropic Medication Consenter (PMC)

A Psychotropic Medication Consenter (PMC) is an employee of a local agency who has completed psychotropic medication consenter training according to the training curriculum and has been designated by the local agency director.

PMCs are typically senior workers, supervisors, director's designees, or directors. As these individuals can carry caseloads, the child's assigned caseworker is not precluded from being the child's PMC. Agencies can develop as many PMCs as needed to meet their agency's demands.

Individuals selected as PMCs are required to possess the following skills and knowledge:

- Ability to facilitate a focused dialogue that results in all information being made available to be utilized in the consenting process.
- Understanding of child development and norms for child and youth behavior, as well as the effects of abuse, neglect, and other trauma on childhood development.
- Understanding and discernment of the short and long-term impact of placement in foster care and subsequent events such as: a change in placement, termination of parental rights, visitation with parents and other family members, a change in permanency goal, etc.
- Understanding of psychotropic medication, side effects, short and long-term impacts, and effective non-pharmacological interventions.
- Ability to use such information to determine whether the approval of psychotropic medication is in the best interest of the child.

The agency is required to certify that any PMC for their agency meets these competencies and has completed the required training through the use of the Psychotropic Medication Consenter (PMC) Certification Form.

The PMC should know the child well enough to make medical decisions, such as knowing the child's medical and case history, current medical condition, allergies, and medication.

The PMC is responsible for granting consent for the child's psychotropic medications through the use of the Psychotropic Medication Informed Consent Form.

12.11.8.4.2 Engaging the family and caregivers

The child's family (i.e. parents, relatives) should participate in medical appointments for the child, including psychotropic medication appointments. A child's family has valuable insight into the child as well as historical information that would be useful at the appointment. As the majority of children in foster care achieve permanency through reunification or custody transfer to a relative, involving family helps support the child's transition as they achieve permanency. The service worker should have ongoing

conversations with the family about psychotropic medication to ensure they understand the child's current medical needs.

Additionally, the current caregiver's input is vitally important. The caregiver has knowledge regarding the day-to-day needs of the child and is able to share how the medication is working and any side effects observed. By involving the caregiver, the local department also helps to support the stability of the placement.

12.11.8.4.3 Engaging the child/youth

Until the child turns 18, they are not legally able to provide informed consent. However, they are able to provide assent which means they are agreeing to the treatment. When psychotropic medication is prescribed for children in foster care, it is important that they are provided an opportunity for input regarding the medication as well as an explanation of the medication in language that is appropriate for their age and development. Children in care should be provided the opportunity to participate in their medical care and medical decisions with the ultimate goal of helping prepare them to make their own decisions when they reach adulthood. PMCs are still responsible for making the decisions regarding psychotropic medications for the child, but the child should be given the opportunity to participate in and understand the decisions made on their behalf. As appropriate for the child's age and development, the child should provide their assent or dissent for the medication. The child should have a say in the decision regarding taking psychotropic medication as they get older. Involving the child in the discussion early on may help them to make better decisions later. However, the PMC is ultimately responsible for the final decision based on what is best for the child.

Involving the child in the discussion is important because of the following:

- Allows the child to feel more in control and helps build trust.
- Helps the child invest in the treatment and may make the treatment more successful.
- Supports the child's decision making once they are an adult.

If a child refuses to provide assent for the treatment, service workers should consult with the child, the prescribing doctor, and the child's treatment team. Depending on the rationale for the refusal, it may be helpful to explore with the child and doctor alternative treatment options, a lower dosage, or a non-pharmacological option. The child should also be provided information regarding the possible effects of refusing the treatment as well as the rationale behind the proposed treatment.

12.11.8.4.4 Transition to adulthood

Once the youth turns 18, they gain the ability to consent or refuse their own medical treatment, including psychotropic medication ([Section 12.11.1.4](#)). The service worker, along with the PMC, should support the youth as they transition to making these medical decisions. The youth's transition plan should contain steps to ensure the youth is educated regarding their prescribed psychotropic medications, elements of informed consent, and applicable resources.

Additional ways to help support the youth as they become their own medical consenters:

- Attach a copy of their current medications and prescribers to their transition plan or provide it to the youth at the time of discharge from care, including a copy of the most recent Psychotropic Medication Informed Consent Form;
- Assist the youth in scheduling their next psychotropic medication appointments, develop a plan for how they will get there, and identify individuals who may be a support to them during these appointments; and
- Provide them additional resources to assist in navigating the decisions around psychotropic medications.

12.11.8.4.5 Reviewing Consents

PMCs provide the initial consent for psychotropic medications and when new medications are added. When the prescriber recommends dosage changes or terminating a psychotropic medication, the service worker may provide consent for those activities. The service workers should use the PMC as an expert resource in discussing concerns and questions, including if the child is still experiencing the referring symptoms or if the child is experiencing side effects. When children are psychiatrically hospitalized, service workers can provide consent for short-term medication in response to an immediate safety threat; however, consent for any changes to the child's ongoing medications needs to be provided by the PMC.

The child's psychotropic medication should be reviewed at every FPM for the child. The FPM provides an opportunity to have a team review process. The PMC may be present at the FPM or use the feedback from the FPM to help inform the review of their consent. The PMC should use the review section on the Psychotropic Medication Informed Consent Form to indicate that a review of the consent has been conducted. If the child's information has changed substantially from the initial consent form, it may be necessary to update the form entirely.

At a minimum, the PMC should be conducting a review of the consent every six months.

12.11.8.5 Resources

For information on psychotropic medications, see:

- [Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care](#) (ACYF-CB-IM-12-03; April 11, 2012).
- [A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents](#) (2012) by the American Academy of Child & Adolescent Psychiatry.
- [Mental Health Medications](#) by the National Institute of Mental Health.
- [Facts For Families](#) by the American Academy of Child and Adolescent Psychiatry
- [Making Healthy Choices](#): A Guide for Caregivers and Caseworkers on Trauma, Treatment, and Psychotropic Medications.

12.12 School placements and education

For children and youth in foster care, a change in foster care placement has frequently resulted in a change in school placement. The educational impact of every school change is significant. Each time children enter new schools they must adjust to different curricula, different expectations, new friends, and new teachers. These changes may create several negative outcomes for children placed in foster care:

- They may make less academic progress, falling behind their peers.
- They may experience less opportunity for academic achievement, increasing the risk for dropping out of school.
- They may face challenges in developing and sustaining supportive relationships with teachers and peers.

Keeping children in the same school:

- Provides continuity in education.
- Maintains important relationships at school.
- Provides stability during a traumatic time for the children.

- Improves educational and life outcomes.

After the LDSS determines the most appropriate home for a school age child (see [Section 6.3](#) through [Section 6.7](#)), the LDSS and the school division shall have a Best Interest Determination (BID) meeting to work together to jointly determine the child's best interest for school placement. The joint guidance document, [Virginia Department of Education and Virginia Department of Social Services Fostering Connections: Joint Guidance for School Stability of Children in Foster Care](#), represents collaboration of these two State departments to promote school stability for children in foster care. The joint guidance may also be found on the Virginia Department of Education's website under [Enrollment of Students in Foster Care](#).

The joint guidance applies to all school age children in both initial and subsequent foster care placements. The joint guidance requirements also apply when the parent retains custody of the child and has entered into a noncustodial foster care agreement with the LDSS to voluntarily place the child in foster care. The updated Client Education Report from OASIS shall be printed and attached to Part A of the youth's foster care plan or the review document each time there is a court hearing.

12.12.1 Communicating with school on child's education

The CPA, in collaboration with the birth parent(s) or prior custodians as appropriate, and the foster and adoptive parent or current placement provider, should:

- Refer the child for an evaluation for determination of eligibility for special education services if he or she is suspected of having a disability.
- Communicate any other special needs or issues the child may have related to school.
- Inform school personnel of foster care requirements, such as regular court dates, the child's permanency plan, and the child's foster care plan, as appropriate.
- Monitor the child's educational progress through attending conferences with school personnel, report cards, performance evidence, and IEP meetings as appropriate, and through maintaining contact with the foster care placement and birth parent(s) or prior custodians.
- Inform the school at any time the child is a subject of a petition alleging the child committed, or was adjudicated delinquent for, any criminal acts listed in [§ 16.1-260 G](#) and provide the nature of the offense.

LDSS may contact the [School Division Foster Care Liaison](#). The Virginia Department of Education's [Superintendent's Memo #306](#) dated December 10, 2010 recommended that each school division designate a point of contact for students in foster care.

12.12.2 School nutrition programs

The Healthy, Hunger Free Kids Act of 2010 provides categorical eligibility for free meals, without further application for foster care children. The school division should obtain documentation indicating the status of the child as a child in foster care in the placement and care responsibility of the state or that the child in foster care has been placed with a caretaker household by a court.

Prior to the Act, a separate application for free and reduced lunch price meals was submitted for a foster child who was considered a household of one. Now, a foster care child is categorically eligible and may be certified without an application with the appropriate documentation.

Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes the non-foster care children. Information should be relayed to the foster family that the presence of a foster child in the home does not convey eligibility for free meals to all children in the household in the same manner as Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF).

When the LEA is processing a household application, the foster care child will be certified for free meals and then an eligibility determination will be made on the remainder of the household based on the household's income (including personal income earned by the foster child).

Foster payments received by the family from the placing agency are not considered income and do not need to be reported.

12.12.3 Regular education services

The local school division shall provide free textbooks required for courses of instruction for children attending public schools ([§ 22.1-243](#)). Other educational services needed by the child and not provided by local school divisions may be purchased using state pool funds. Some educational services may be purchased from independent living funds for youth ages 14 and over.

12.12.3.1 When regular education services may be purchased

- To achieve an educational goal;
- They are not the responsibility of state and/or local education agencies;
- Services are not available without cost; or
- Charges for services are the same to all residents regardless of income.

12.12.3.2 Educational services that may be purchased

- Normal school expenses such as school trips, summer school, gym suits, fees for labs, art classes, etc., and school supplies.
- Tutoring.
- Training for employment if no other resource exists.
- Tuition and fees, school supplies, textbooks required for college degree or vocational education.
- Tuition and fees, etc., for placement in a private school or private day school for the child who is not eligible for special education. In this instance, the child's foster care paper case record shall document that:
 - All other resources to meet the child's specific need have been explored.
 - These resources have been determined to be inadequate to meet the child's needs.

Note: Students receiving special education services shall be placed in a school setting in accordance with their IEP.

12.12.3.3 Other school-related expenditures

Expenses related to school activities that are not necessary to meet an educational goal such as class rings, club dues, and prom fees may be purchased from Chafee Independent Living Funds for youth ages 14 years and older, private donations, and local only funds. After all other funding sources are pursued and determined not available, state pool funds may be used based on CPMT procedures.

12.12.3.4 Additional education requirements

The most recent information available regarding the child's educational status, including:

- The child's State Testing Identifier (STI) Number for the child of compulsory age for school attendance, meaning the child was age five (5) on or before September 30 of the school year through his or her 18th birthday ([§ 22.1-254 A](#)). The sole purpose of documenting the STI number is to allow VDSS to obtain educational outcome information on children in foster care from the Virginia Department of Education.

- If an STI number cannot be entered despite reasonable efforts to obtain the number, document the reasons on the foster care plan. Younger children or older youth may have an STI number which shall be entered.
 - The STI number is confidential by law and shall be protected by LDSS as all confidential child information is maintained (§ [63.2-104](#)). The STI number shall only be entered into OASIS. The STI number will only appear on the OASIS screen; it does not appear on the previewed or printed foster care plan. Do not write the number on the printed foster care plan or include it in the body of the foster care plan.
- How to get the number:
 - The STI number is located on the student's SOL Report or the LDSS may contact the person responsible for student records at the child's school to obtain the number.
 - For the child who entered foster care through a non-custodial foster care agreement, the LDSS shall request the child's parent who has legal custody of the child to obtain the child's STI number from the school.
- A summary of activities demonstrating that during initial and subsequent placements of a child, the LDSS:
 - Took into account the appropriateness of the child's current educational setting and the distance from potential placements to the school in which the child was enrolled (e.g., talked with representative from current school, the conclusions reached on the appropriateness of the educational setting, and the distance from potential placements).
 - Made the placement decisions and immediately coordinated with the child's school to ensure the child remained enrolled in the same school in which he or she was enrolled prior to the placement change, unless contrary to the child's best interests (e.g., met with key partners to determine child's best interest, the determination made at the meeting, the best interest determination form placed in the child's case record).
 - Immediately and appropriately enrolled the child in his or her new school when it was in the child's best interest to change schools (e.g., child was presented to school with all required documents; immediate enrollment form placed in the child's case record).

- Statement that the school-aged child is either enrolled as a full-time student and is:
 - Enrolled in elementary, middle, or high school;
 - Instructed at home in elementary or secondary education, in accordance with home schooling laws and requirements;
 - Instructed in an independent study program for elementary or secondary education that is administered by the local school division, in accordance with education laws; or
 - Incapable of participating in school full-time due to a medical condition that is documented by a qualified professional and updated quarterly or more frequently based on the child's condition;
 - Or, the school-aged child has completed secondary school:
 - Graduated from high school;
 - Earned a Board of Education-approved career and technical education certification.
- And whether the older youth:
 - Is enrolled full-time in an institute of higher education, technical college, or community college; or
 - Has completed two year or four year college/university.
- List of information available in the child's case record, including:
 - The names and addresses of the child's educational providers.
 - The child's school record, including attendance, and Individualized Education Plans (IEP), 504 plans, or gifted status, as appropriate.
 - The child's performance in school, including report card and standards of learning tests results.
- Any other relevant educational information concerning the child.

12.12.4 Special education services

- School divisions are mandated by law to provide, without cost, instruction specifically designed to meet the unique needs of children with disabilities, ages 2 through 21 ([§ 22.1-214](#)).

- A child is determined eligible for special education and related services by an eligibility team at the school. This team uses data gathered through a comprehensive evaluation. The school division may use data provided by the LDSS or other source (e.g., psychological, medical, hearing or vision screenings/evaluation, and sociocultural evaluations). This team makes its decision for such services no later than 65 business days after the referral for the evaluation is received by the division.
- The school division shall develop an individualized education program (IEP) **within 30 calendar days** after eligibility has been determined.

If the child's parent cannot be found or parental rights have been terminated, school divisions are required by law to train and appoint surrogate parents to represent the educational interests of the children, which may include those in the custody of the LDSS. When a surrogate parent is appointed, that individual holds the same rights and responsibilities relative to the child's education as are afforded to parents. Local school divisions may appoint the foster parent as the surrogate parent under certain circumstances. The school division may recognize the foster parent as parent when the child is in permanent foster care. Additionally, the permanent foster care parent shall have an ongoing, long-term relationship with the child, is willing to make the educational decisions required of the parent under the regulations governing special education, and has no interest that would conflict with the child's interests.

- A surrogate parent is not required for a child in a non-custodial placement. The parent or guardian is responsible for requesting services and signing IEPs. The federal Individuals with Disabilities Education Act ([P.L. 108-446](#)) prohibits LDSS staff from serving as parents (or surrogate parents) for children in custody.
- If the child's parents (which includes birth parents, adoptive parents, permanent foster parents in the situation described above, or surrogate parent) disagree with the evaluation conducted by the school division, they may request an independent evaluation at public expense.
- If the LDSS or foster parents have any concerns or disagreements about a foster care child's special education program or implementation of the special education procedures, the service workers should first contact the director of special education in the local school division for resolution. If resolution is not achieved at the local level, the LDSS may contact the Virginia Department of Education's Dispute Resolution and Administrative Services unit in the [Division of Special Education and Related Services](#) for more information about mediation, complaints, and due process hearings.

12.12.4.1 Local school responsibility

Local school divisions are responsible for paying for special education services identified on the child's Individual Education Program (IEP) when the child is placed within the school system or regional special education program.

When a child is placed in another jurisdiction, the receiving local school division should seek reimbursement for education costs from the Virginia Department of Education for any children receiving foster care services. (§§ [22.1-101.1](#) and [22.1-215](#)).

12.12.4.2 Length of time child is eligible for special education services

A child is eligible for special education services until he or she:

- Is found to be no longer eligible by an eligibility team;
- Graduates with a regular or advanced diploma; or
- Reaches age 22 by September 30 of the year.

The local school division where the LDSS is located that has custody of the child is responsible for the child's special education services. In the event that a child is placed in foster care in a different jurisdiction and the child can be educated in the public school or a regional program that includes that jurisdiction, the school division where the child is placed is responsible for the child's education.

12.12.4.3 Use of state pool funds for special education services

- State pool funds are to be used to purchase special education and related services for a child placed in a residential facility approved for special education or private special education day school in accordance with the child's IEP. Related services include such services as developmental day programs, infant/child stimulation, training to maximize independence, and sheltered workshops. Procedures to access state pool funds for these placements will be based upon CPMT policies. Maintenance for title IV-E eligible children would be paid from title IV-E funds and from state pool funds for non-title IV-E children.
- In addition, the [CSA Manual](#) (Section 4.3.3a) specifies how state pool funds may be used to keep a child in a less restrictive special education environment, when the FAPT makes such a determination and includes it on the IFSP.
- If a child is placed in a facility for special education and is subsequently determined ineligible for special education, removal of the child from the

facility or continued funding of services for that child in the facility will be based on local CPMT procedures. The LDSS, in coordination with the FAPT, is responsible for ensuring that an appropriate placement is provided for the child.

12.12.4.4 Cross-jurisdictional placements

The cost of purchasing special education and related services, where applicable, for children in cross-jurisdictional placements will be covered by the placing agency's school division through the policies of the CPMT. This also applies to children in permanent foster care placements or adoptive placements prior to the final order. If a child is served in a public school, the receiving school division pays for the services. All special education needs shall be included on the IEP in accordance with federal law.

12.13 CSA services

The Children's Services Act (CSA) establishes a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the needs of troubled and at risk youth and their families. One of the targeted populations is children and youth for whom foster care services, as defined by [§ 63.2-905](#), are being provided.

12.13.1 CSA foster care services

Foster care services are the provision of a full range of casework, treatment and community services including but not limited to independent living services, for a planned period of time to a child or youth who has been abused or neglected, or in need of services, or a family who a child or youth has been identified as needing services to prevent or eliminate the need for foster care placement, a youth or child who has been placed through an agreement between the LDSS or the public agency designated by the CPMT and where legal custody remains with the parents or guardians, or has been committed or entrusted to an LDSS or licensed child placing agency. Foster care services also include the provision and restoration of independent living services to a person who is over the age of 18 years but who has not reached the age of 21 years who is in the process of transitioning from foster care to self-sufficiency.

Access to CSA funds is governed by state and local policies which require multi-agency planning, uniform assessment, utilization review, and authorization of funds. The LDSS service worker should become familiar and comply with policies established by their local Community and Policy Management Team for access to CSA funding.

12.13.2 Role of LDSS when collaborating with FAPT

The LDSS shall refer the child and family to the Family Assessment and Planning Team (FAPT) or approved multi-disciplinary team, consistent with CMPT policies. As part of this process, the LDSS shall ensure the child is assessed using the mandatory uniform assessment instrument (§ [2.2-5212](#)). See [Section 5.9.1](#) for information on the Child and Adolescent Needs and Strengths (CANS) tool.

The LDSS shall assist the FAPT, consistent with CPMT policies, in:

- Engaging the family to participate in all aspects of assessment, planning, and implementation of services.
- Assessing the unique strengths and needs of the child and family.
- Identifying and/or creating the services and/or supports to be provided to the child and family. This process involves exploring:
 - Family and community based services first.
 - Placements with extended family and individuals who can effectively care for the child whenever possible, if family based services are not in the child's best interest.
 - Family like homes when there are no viable placements for the child with extended family and individuals.
 - Short term residential treatment programs when these are the most appropriate, least restrictive, and cost effective services for the child.
- Ensuring all appropriate community services for the child have been explored before placing the child across jurisdictional lines (§ [2.2-5211.1 2](#)).
- Maximizing and pooling resources across agencies and sectors by helping to explore all available family, private insurance, community, LDSS, and other public resources that may assist in funding the services and supports.
- Developing the individual family services plan (IFSP) or using the foster care plan.
- Referring the child and family to services delineated in the plan, when appropriate.
- Helping to coordinate services with the child and family, when designated to serve this role by the FAPT (§ [2.2-5208](#)).

- Helping to conduct ongoing utilization management to assess the effectiveness and appropriateness of services provided, when requested by the FAPT ([§ 2.2-2648 D15](#)).

The LDSS shall include the Foster Care Plan or the Individual Family Service Plan (IFSP) developed by the FAPT or approved multidisciplinary team in the child's foster care paper case record.