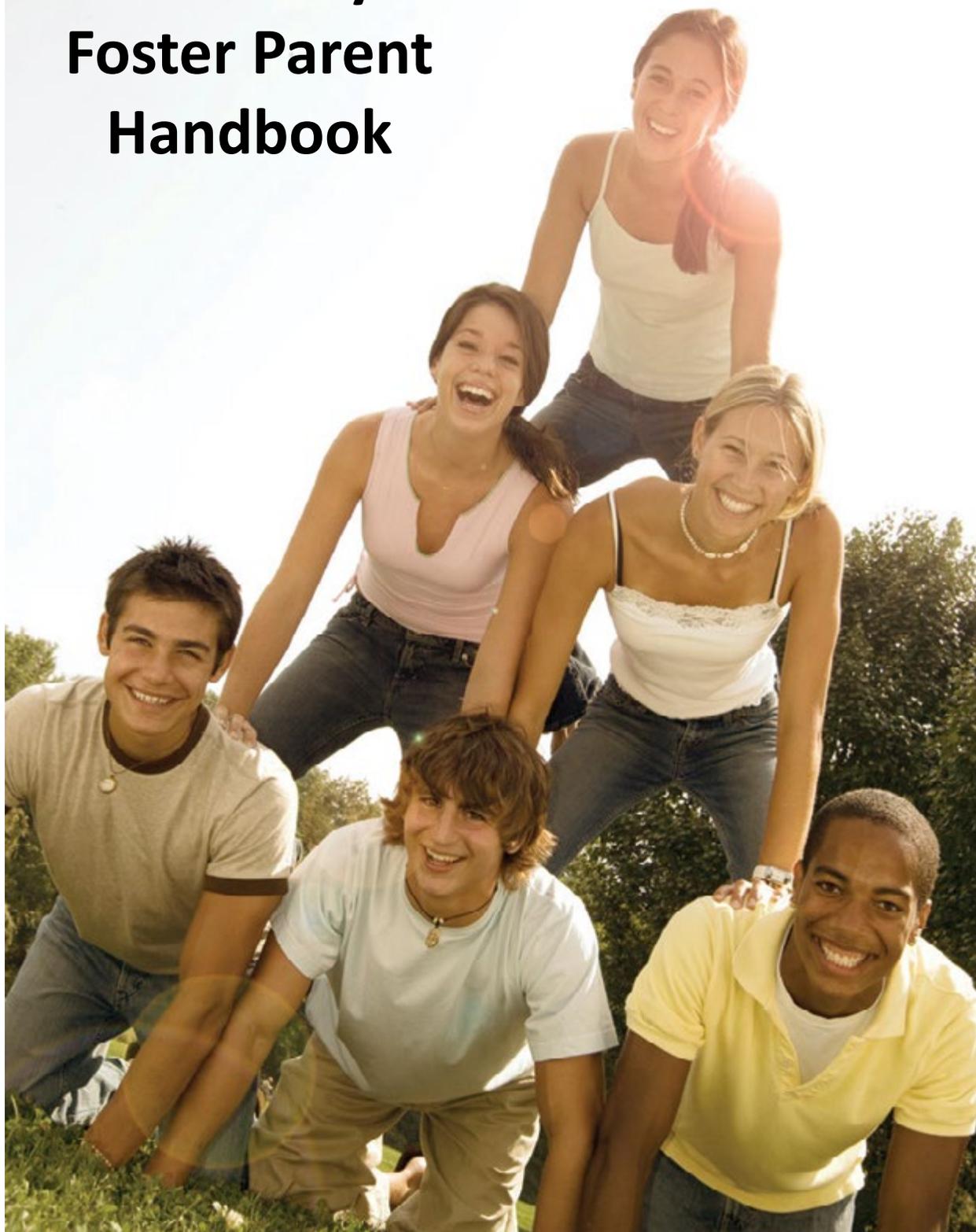


Kentucky Foster Parent Handbook





Printed in part or whole with state or federal funds.

Kentucky's Foster Parent Handbook

2016 Edition



Foster or Adopt a Child
Kentucky Cabinet for Health and Family Services

<http://chfs.ky.gov/dcbs/>

UK
UNIVERSITY OF
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College of Social Work
Training Resource Center

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PURPOSE

The information in this handbook comes from recommendations made by foster parents like you and Department for Community Based Services (DCBS) staff. This is a basic guide about the roles and responsibilities of foster parents and was derived from the DCBS standards of practice (SOP) manual. Please note that because SOP changes may occur more frequently than revisions of this handbook, please access the current SOP at the DCBS manual website:

<http://manuals.sp.chfs.ky.gov/Pages/index.aspx>

SOP is based on Kentucky's current legislation. You may access this information at:

<http://www.lrc.ky.gov/statutes/>

Though much of this handbook's information comes from the DCBS SOP manual, it is not intended to be all inclusive of departmental standards of practice.

MISSION

The mission of DCBS is to protect children from abuse and neglect by partnering with families, the community and caregivers to deliver quality services to enhance and promote the health, safety and well-being of families across Kentucky.

BILL OF RIGHTS FOR CHILDREN IN OUT-OF-HOME CARE

Ratified in Congress Hall, Philadelphia, Saturday, the Twenty eighth of April, Nineteen Hundred and Seventy Three; Reaffirmed During the National Focus on Foster Care Conference, Norfolk, Virginia, Wednesday, the Fourth of May, Nineteen Hundred and Eighty Three, EVEN more than for other children, society has a responsibility along with parents for the well-being children in foster care. Citizens are responsible for acting to ensure their welfare.

EVERY child is endowed with the rights inherently belonging to all children. In addition, because of the temporary or permanent separation from or the loss of birth parents and other family members, the child is required special safeguards, resources and care.

Every child in out-of-home care has the inherent right:

- Article the First ...to be cherished by a family of his own, either his family helped by readily available services and supports to reassume his care, an adoptive family or, by plan, a continuing foster family.
- Article the Second ...to be nurtured by foster parents who have been selected to meet his individual needs, and who are provided services and supports, including specialized education, so that they can grow in their ability to enable the child to reach his potential.
- Article the Third ...to receive sensitive, continuing help in understanding and accepting the reasons for his own family's inability to take care of him, and in developing confidence in his own self-worth.
- Article the Fourth ...to receive continuing loving care and respect as a unique human being, a child growing in trust in himself and in others.
- Article the Fifth ...to grow up in freedom and dignity in a neighborhood of people who accept him with understanding, respect and friendship.
- Article the Sixth ...to receive help in overcoming deprivation or whatever distortion in his emotional, physical, intellectual, social and spiritual growth which

may have resulted from his early experiences.

- Article the Seventh...to receive education, training, and career guidance to prepare for a useful and satisfying life.
- Article the Eighth...to receive preparation for citizenship and parenthood through interaction with foster parents and other adults who are consistent role models.
- Article the Ninth...to be represented by an attorney-at-law in administrative or judicial proceedings with access to fair hearings and court review of decisions, so that his best interests are safeguarded.
- Article the Tenth...to receive a high quality of child welfare services, including involvement of the natural parents and his own involvement in major decisions that affect his life

TEAM APPROACH/CASE PLANNING CONFERENCES AND TEAM MEETINGS

As a foster parent, you will become a vital member of the team that will meet regularly to share information and make recommendations about children placed in your home. Team members will include but are not limited to the child's social services worker, birth parents, relatives, and other connections important to a child, community partners, therapists, physicians and attorneys, including the child's guardian ad litem.

Upon a child entering the state's custody, the child's social services worker will convene a case planning conference, which is generally referred to as a "five-day conference".

Your presence and participation during this meeting is important. You will receive critical information about the child placed in your home to assist you in caring for the child. This meeting provides an opportunity to ask questions and gather information about the child. A visitation plan with the child's birth parents and siblings will be established during this meeting. You will play a critical role in supporting the visitation plan. Prior to and following visits, you will be communicating with birth parents about how a child is doing in your home. Following the initial five-day conference, subsequent periodic case plan conferences will be scheduled and held every six months to review and discuss the family and child's progress. Additionally, a "family team meeting" will be scheduled 90 days after the child's entry into care to review progress and engage relatives who may be considered for placement.

A family team meeting is an opportunity for family and their support systems to come together in a guided discussion to create a plan that may include resources, interventions and services to assist the family.

Working as a member of a professional team can be challenging for various reasons. The issues may be emotionally charged. There are many parties and factors involved - different agencies, the legal system, relatives and birth family. Sometimes there is conflict between the legal responsibility and the attachment the child has with the foster family. Different team members come not only with their expertise, but also with their own perspective, and teamwork may be a new idea for some, which can be overwhelming.

While teamwork is definitely challenging, there are some guidelines or concepts to help the team better achieve their goals. Team members need to share child welfare values and respect for child welfare laws. When team members value the child's relationships,

it is easier for the team to work together toward supporting those relationships. Likewise, when there is an understanding of the legal issues in child welfare it helps team members to better understand the mandate and responsibility of the agency. In issues as emotionally charged as attachment, separation and loss and child abuse, there will not always be shared values.

Different members of the team have different expertise to offer. The use of complementary skills is one of the greatest values of teamwork. But members, by virtue of their differing roles and skills, also come to the team with different perspectives. Perspectives do not need to be judged right or wrong, but rather need to be considered as part of the overall decision making. If the team does not value its members' perspectives, valuable information may be lost and the child will suffer from that loss.

Team members need to have a clear understanding of the goals and objectives in working with children and families and ensure these are shared among team members. When you are a team member, you cannot base your actions on your own assessment of a situation. The team needs to share information and ensure there is a common understanding of the goal and the work to be done to achieve that goal.

There is a common misconception that teamwork is a natural occurrence instead of a process that takes practice. Let us take the challenge and practice teamwork for our children.

Understanding your role and the rights, responsibilities and expectations of foster and adoptive parents in Kentucky is crucial in helping you to provide the day-to-day care for children placed in; your home. These rights are outlined in Standard of Practice (SOP) 12.10, Rights/Responsibilities and Expectations of DCBS Foster and Adoptive Home Parents.

RIGHTS OF DCBS FOSTER PARENTS

The Cabinet will strive to ensure that foster and adoptive home parents:

1. Are provided a complete understanding of the role of the Cabinet and the role of other members of the foster child's professional team (all workers, community partners, etc.);
2. Are treated with respect, consideration, and dignity;
3. Are provided timely information about available trainings to improve skills in the daily care and in meeting the special needs of foster children;
4. Are provided information on support systems for foster and adoptive parents;
5. Are provided timely and adequate financial reimbursement for services provided as outlined in the foster and adoptive home reimbursement section of this SOP chapter (SOP 12.24-12.32);
6. May maintain their normal routines and values while respecting the federally protected cultural, religious, and confidentiality rights of the foster child placed in the foster and adoptive home;
7. Upon request, are provided information on how to obtain their Provide case file through an open records request as described in SOP 30.11 CPS Open Records Request and Disclosure of Information;
8. Are provided with all information regarding any child placed in their home that may jeopardize the health or safety of any member of the foster family's

household, including other foster children placed in the home, as outlined in KRS 605.090(1)(b);

9. May refuse placement of any foster child without fear of reprisal;
10. May request removal of a foster child from the home without reprisal as outlined in the DPP-111A Foster and adoptive Home Contract Supplement;
11. May, with appropriate informed consent as outlined in SOP 1.17 Informed Consent and Release of Information, communicate with other professionals who work directly with the foster child, including but not limited to teachers, therapists, and health care practitioners;
12. Are provided an explanatory notice within fourteen (14) business days of the following items, except in the immediate response to a CPS investigation involving the foster and adoptive home:
 - (a) Change in the foster child's case plan;
 - (b) Change of placement; or
 - (c) Termination of placement;
13. Have the right to participate in the development of the child's case plan;
14. Are provided, when in the best interest of the child, priority placement consideration of a foster child who has been previously placed in the foster and adoptive home;
15. Are provided, when in the best interest of the child, priority placement consideration of a foster child is eligible for adoption;
16. May maintain contact with the foster child after the child leaves the foster home, unless any of the following object:
 - (a) The child;
 - (b) The biological parent(s);
 - (c) The other foster and adoptive home parent(s) where the child now resides; or
 - (d) The Cabinet (if retaining custody);
17. Have the right to access Cabinet staff twenty-four (24) hours a day, seven (7) days a week when a child is placed in the foster and adoptive home to address crisis problems.

EXPECTATIONS OF FOSTER AND ADOPTIVE HOMES PROVIDING FOSTER CARE SERVICES

Unless specified in a contract between the Cabinet and a child welfare agency that provides foster care services, a foster and adoptive parent only accepts a child for foster care from the Cabinet.

Foster and Adoptive Parents:

- Provide temporary supplemental care to a child and prepare the child for movement into a permanent home;
- Participate in case planning conferences concerning a child placed by the Cabinet;
- Cooperate with the implementation of the permanency goal established for a child placed by the Cabinet;

- Provide structure and daily activities designed to provide affection and promote the individual physical, social, intellectual, spiritual and emotional development of the children in their home. This may include:
 - Approving developmentally and age-appropriate opportunities for activities, which stimulate the growth and development of the child;
 - Assisting the children to develop skills and to perform tasks, which will promote independence and the ability to care for themselves;
 - Cooperating with the Cabinet to help the children maintain an awareness of their past, a record of the present, and a plan for the future; and
 - Work responsibilities reasonable for the child's age and ability and commensurate with those expected of the foster and adoptive family's own children; and
 - Selecting occasional short term babysitters, for periods of twenty-four (24) hours or less, as outlined in SOP 4.30, Normalcy for Children in Out of Home Care.
- Are to review and sign the DPP-1291 Foster and Adoptive Home Discipline Policy Agreement;
- Should recognize that most children in out-of-home care have been abused, neglected, emotionally maltreated, or sexually exploited;
- Can expect that some children may anticipate harsh treatment based on previous life experiences and may misbehave to test the boundaries.
- Are expected to use the discipline techniques described in preservice family preparation training process. Appropriate discipline considers the age and developmental needs of the child;
- May not:
 - Use any form of corporal punishment;
 - Deny food, shelter, or clothing;
 - Interfere with implementation of the child's case plan;
 - Deny visits or contact with family members;
 - Have the child engage in extremely strenuous work or exercise; or
 - Act in bizarre, severe, cruel or humiliating ways (e.g. verbal abuse, derogatory remarks to the child or about the child's family, or make threats of removal from the foster home);
- Treat all children placed into a foster and adoptive home with dignity;
- Arrange for respite care services as described in SOP 12.12 Respite Care;
- Are to cooperate with the Cabinet in planning for the medical and dental care needs of the child by:
 - Scheduling appointments as needed;
 - Keeping immunizations current;
 - Reporting to Cabinet all encounters with medical providers and any corrective or follow-up medical or dental care the child needs;
 - Maintaining the medical passport, as outlined in SOP 4.26.1 Medical Passport with all medical information relating to the health history and on-going medical care of the child;

- Assisting the Department for Protection and Permanency (DPP) in obtaining an initial health screening within forty-eight (48) hours of placement of the child; and
- Assisting DPP in transporting children to necessary health-related (e.g. mental health, medical, dental, vision) appointments as needed;
- Are to give a child's prescribed medications, as described above, only with a physician's prescription or authorization, and are to dispense the exact amount of any medication prescribed for a child by a physician or dentist and may not stop medication without a physician's orders. Prescription medication disposal is documented on the DPP-106H Medication Administration History as applicable;
- Facilitate the delivery of medical care to a child placed by the Cabinet as needed, including:
 - Administration of medication to the child and daily documentation of the medication's administration on the DPP-106H Medication Administration History form. Due to the potential severity of any adverse reaction, ALL medications (over-the-counter and prescription) are documented on this form;
 - Annual physicals and examinations for the child;
- Are to inform the agency within one (1) working day of any psychotropic medication prescribed for a child;
- Is to treat personal or protected health information shared by the Cabinet concerning a child placed by the Cabinet, or the child's birth family, in a confidential manner, disclosing confidential information only to personnel who are directly assisting the child (e.g. worker, mental health professionals, school counselor, etc.);
- Cooperate with the Cabinet when a contact is arranged by Cabinet staff between a child placed by the Cabinet and the child's birth family including:
 - Visits;
 - Telephone calls; or
 - Mail;
- Supports and promotes family connections for children in their care including the involvement of fathers and their family members. Attachment should be promoted through:
 - (a) Regular and frequent visitation with all family members as outlined in SOP 4.17 Visitation Agreement;
 - (b) Phone calls;
 - (c) Mail; and
 - (d) Inclusion of the parent in other various activities in which the child is involved;
- Provide positive processing of all contact (phone, visitation, etc.) with family members, including fathers;
- Support an assessment of the service needs of a child placed by the Cabinet;
- Encourage family connections through their assistance in developing the child's Lifebook;
- May make decisions regarding haircuts and hairstyles for foster children if the

foster and adoptive home parents have cared for a child for more than thirty (30) days or the child's parents/caretaker have had their rights terminated (TPR) by the court;

- Ensures with the R&C worker that the foster child does not meet special circumstances for religious or cultural exemption. For example, in Native American and certain Apostolic Christian faiths, cutting the hair may be a violation of their religious rights and cultural traditions;
- Are to provide well-balanced daily meals and are encouraged to eat together as a family.
- Are to have snacks available for children, and are to provide for any special dietary needs of children placed in their home;
- Maintains a record of clothing expenditures;
- Are to provide each child with their own clean, well-fitting, attractive and seasonal clothing appropriate to age, sex and individual needs, and comparable to the clothing of their own children and community standards. The children should be included in the choosing of their own clothing when possible;
- Are to allow children to bring and acquire personal belongings;
- Send all personal age-appropriate clothing and belongings with the children when they leave the foster and adoptive home;
- Are to establish and enforce age-appropriate curfews for adolescents;
- Ensure that children under age fourteen (14) thirteen (13) are not to be left without responsible supervision;
- Are to:
 - Ensure that a child in the custody of the Cabinet provides the child's designated per diem allowance for the child's discretionary spending at the rate set by the Cabinet in the foster home contract; and
 - Encourage children to establish savings accounts;
- Are NOT to:
 - Demand that allowance money be spent on family activities initiated by the foster and adoptive home parents; or
 - Accept any part of a child's earned or unearned income without prior, written agreement of Cabinet and the child;
- Provide opportunities for development consistent with the child or child's families religious, ethnic, and cultural heritage, the foster and adoptive home parent is to:
 - Recognize, encourage and support the religious beliefs, ethnic heritage and language of a child and the child's family;
 - Arrange transportation (whenever possible) to religious services or ethnic events for a child whose beliefs and practices are different from their own;
- Are not to coerce or force children to participate in religious activities or ethnic events against their will or beliefs;
- Enroll each child of school age in school within three days of the placement of the child (exceptions may be made by the FSOS);
- Cooperate with Cabinet in the selection and arrangements for educational

- programs appropriate for the child's age, abilities, and case plan;
- Problem-solve (with school personnel) when there are any problems with the child in school;
 - Obtain SRA or designee approval to enroll a child in a state or federally accredited home school or a private school and not in public school;
 - Report to the SSW or R&C worker any serious situations that may require their involvement;
 - Provide opportunities and transportation for recreational activities, which are appropriate to the age and abilities of the child, and are to encourage children to take part in community services and activities both with the family and on their own;
 - Present a positive image of the child's family to the child;
 - Demonstrate respect for the child's own family;
 - Agree to work with the child's family members as indicated in the child's case plan; and
 - Participate in the development of the visitation agreement and allow children and their family members to visit and communicate in accordance with the visitation agreement;
 - Permit Cabinet staff to visit the child;
 - Provide the SSW with all pertinent information about a child placed in their home by the Cabinet;
 - Provide independent living soft skills for a child age twelve (12) and older;
 - Surrender a child to the authorized representative of the Cabinet upon request;
 - Comply with the general supervision and direction of the Cabinet concerning the care of a child placed by the Cabinet;
 - Report immediately to the Cabinet if there is a:
 - Change of address;
 - Medical condition, accident or death of a child placed by the Cabinet;
 - Change in the number of people living in the home;
 - Significant change in circumstance in the foster and adoptive home such as:
 - Income loss;
 - Marital separation; or
 - Other household stressors;
 - An absence without official leave (AWOL);
 - A suicide attempt; or
 - Criminal activity by the child requiring notification of law enforcement;
 - Notify the Cabinet when:
 - Leaving the state with a child placed by the Cabinet for more than two (2) nights twenty-four (24) hours;
 - A child placed by the Cabinet is to be absent from the foster and adoptive home for more than three (3) days;

- Notify the Cabinet at least ten (10) fourteen (14) calendar days in advance of the home's becoming intent to become certified to provide foster care or adoption services through a private child-placing agency in accordance with 922 KAR 1:310;
- Report suspected incidents of child abuse, neglect, and exploitation in accordance with KRS 620.030

PERMANENCY GOALS

There are six possible permanency goals in out-of-home cases. There is only one goal for a case at any time during a case. The other possible goals can be objectives if appropriate for a case. In order of least restriction, the goals are:

1. Return to Parent
2. Permanent Relative Placement
3. Adoption
4. Planned Permanent Living Arrangement
5. Guardianship



There are some children in out of home care who are available for adoption and do not have an identified adoptive family. These children are placed in the Special Needs Adoption Program (SNAP).

SNAP

The SNAP program specializes in finding families for children who are the least likely to be adopted. There are a number of factors that contribute to the challenge of recruiting families for these children including, but not limited to the following factors: Available children include Caucasian children over the age of six and children who are members of a minority group consisting of various ages (usually over 4 years of age); children who are members of a sibling group; children who may have a physical, educational or developmental delay; and children who may have emotional and behavioral issues related to trauma, common among foster children.

All of the children who are available for adoption through SNAP, have spent time in foster care due to circumstances that have made it necessary for them to be removed from the care of their biological parents. The children who appear on the SNAP website are legally available for adoption because their parents have had their parental rights terminated by a Kentucky Family/Circuit Court judge. The judge's ruling has been finalized and the parent's appeal process has expired or been exhausted. In other words, the biological parents are not able to come back and seek custody of the children.

Adoption is an extraordinary way to grow a family and it comes with challenges that are unique to special needs adoptions. For this reason, it's helpful for SNAP families to have support from their extended family; friends; community; schools; and employers. Many companies offer family leave for new parents to help them adjust to being new parents, so it's important to check the employers medical leave policies. A child adopted through SNAP may be eligible for an adoption subsidy (to help with day-to-day expenses) from the state agency, and the child's social worker can provide resource information to parents to help connect them locate support groups for adoptive parents.

WENDY'S WONDERFUL KIDS RECRUITER (WWKR)

In 1990 Dave Thomas, the founder of Wendy's Restaurants was asked to head a public service campaign to bring attention to the many children in foster care who needed to be adopted, as Thomas himself was adopted as a foster child. As Thomas became an advocate for foster care adoptions, he established The Dave Thomas Foundation for Adoption. The one single goal of the DTFA is to make sure every child has a permanent and loving family. Through that goal, in 2004, the grant-based Wendy's Wonderful Kids service program was launched. Wendy's Wonderful Kids Recruiters are adoption professionals who diligently search for forever families for children in foster care. So, with the help of the child, the DCBS worker, and the child's network, the Wendy's Wonderful Kids Recruiter work to search and locate adoptive families specific to that child. The wonderful thing about the WWK program is that it is child-specific recruiting to match a family to a child, not to make a child fit into a family. The WWKR gets to be that child's advocate through the adoption process to secure a loving and permanent family.

PLACEMENT INFORMATION

The placement of siblings together is a priority. When a child is placed in the care and custody of the Cabinet for Health and Family Services, whether separately or as a part of a sibling group, efforts are made to reunite the sibling group whenever possible. Siblings should be reunited in a placement, at the earliest time possible, unless it is determined not to be in the child's best interest. Foster parents should facilitate and support visitation and contact between siblings who are separated whenever possible and appropriate.

RELATIVE PLACEMENT

Under the law Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) the Cabinet is required to make diligent searches for relatives. Relative Placements offer a less restrictive environment for a child and are less traumatic. They offer the opportunity for healthy development. It is critical for other foster parents to share information from the child or other sources about potential relative placements with DCBS.

KEYS TO SUCCESSFUL PARTNERSHIP WITH THE BIRTH PARENTS

Unless the courts have terminated parental rights, the birth parents have certain responsibilities in planning and decision-making for their child. Some, but not all, of the rights and responsibilities of the birth parents identified by law are the:

- Right to visitation
- Right to voluntarily consent to adoption
- Right to determine religious affiliation, and
- Responsibility to provide support.

Many birth parents work with DCBS during the removal and return of their child to their home. During that period, birth parents are encouraged to maintain regular contact with the social worker and actively work to improve the conditions that led to the child's placement. Parental cooperation and participation in the placement of their child in foster care is essential in helping to relieve the child's fears, anger and guilt about separation from them.

BUILDING A RELATIONSHIP WITH THE CHILD'S PARENTS

Here are some examples of how you can create and maintain a working relationship with your foster child's parents:

- Praise and recognize decisions and activities related to positive parenting,
- Create a Lifebook for the child, or
- Help the child buy/make and send their parents a birthday or holiday card.

Some suggested topics for discussion between foster parents and birth parents include:

- School conferences, functions and PTA meetings,
- The child's clothing and shopping plans,
- The child's health, behavior or school experience,
- The child's social activities, relationships (including siblings), social development and special needs,
- The child's visits to the doctor or dentist, and
- Plans for holidays that are special to the child, e.g. birthday parties, graduations and holiday celebrations.

The intent of these activities is to engage the child's parents in the lives of their children. Be sure, however, not to promise that you will keep from the social services worker information given by the parents.

PARTNERSHIP WITH THE SSW

It is the social services worker's (SSW) job to represent DCBS, the child, and the birth family. They function as a facilitator in meeting the needs of the child and all who are involved in helping the child. The SSW understands that the nature of the work is to develop a partnership that works. Because foster parents have contact with the SSW at least monthly, ideally, the SSW and foster parents will develop a team relationship. This benefits the child and makes your life easier as well.

PARTNERSHIP WITH THE RECRUTMENT AND CERTIFICATION (R&C) WORKER

The R&C worker's job is to represent DCBS and the foster parents. They visit the foster home at least quarterly to verify and document an approved foster home's compliance with ongoing requirements. Your R&C worker is your connection to ongoing training and verifies that you receive appropriate on-going training before the anniversary date of the original approval of your home. The R&C worker provides information, education and support to the foster home in any identified area of need.

THE KEY TO MAINTAINING SUCCESS IS SUPPORT

Support is defined as giving strength or courage; to help or assist; or to maintain, keep up, or keep going. Being part of a support group is highly recommended as a valuable resource for foster parents. Local support groups may be available by county or region. Call your R&C or the child's social worker for information in your area. A support group may enable foster parents to build relationships and companionships. They can provide training, education, advice and supportive information that might not be available otherwise. A support group can also identify problems that are not limited to an individual situation and can suggest approaches to problem solving. Support groups are an essential part of foster care. They are a means to provide connections to community support, community awareness and teamwork. Collectively, foster parents can bring about positive change to better serve children in care.

• The Kentucky Foster/Adoptive Care Association



The Kentucky Foster/Adoptive Care Association (KFACA) is sponsored by the Department of Community Based Services. The Association was formed in October 1987 and has been striving to grow and support families in Kentucky through the years. Members of the KFACA help unite foster and adoptive families, social workers and interested citizens across Kentucky. The KFACA enables members to have a voice for the children placed in foster care in Kentucky and across the Nation. As a current member of the Kentucky Foster/Adoptive Care Association, you are:

- Able to collectively advocate for the needs of foster and adoptive families at both a state and national level;
- Able to network in a group that offers a wealth of information on how to partnership with your child's worker to activate services for children;
- Able to attend scheduled membership meetings and hear what other foster and adoptive parents are involved in across the state as well as, the most up-to-date information from DCBS concerning foster and adoptive families; and
- Attend quality training in conjunction with scheduled membership meetings on a wide variety of topics addressing current issues facing foster and adoptive families and their children. The Cabinet is able to reimburse foster parents for mileage and babysitting to attend these trainings.

Individuals or families may become members of the KFACA with a membership fee paid annually and renewed each January. Local foster/adoptive care associations are also eligible for chapter membership.

- ❖ Please contact the DCBS Central Office at 502 564-2147 and ask to speak with someone about the current KFACA meeting and training schedule.
- ❖ Visit your KFACA on the web at www.kfaca.com

• Local Foster/Adoptive Care Associations



Most regions have at least one local foster/adoptive care association. Some have several. Check with your R&C worker to find out where the nearest one is so that you can find the support you need from other foster parents in your area.

- ❖ Please contact your R&C worker for more information.

- **The National Foster Parent Association**

The National Foster Parent Association is the only national organization that strives to support foster parents and remains a consistently strong voice on behalf of all children. Their purpose is to bring together foster parents, agency representatives and community people who wish to work together to improve the foster care system and enhance the lives of all children and families;



- Promote mutual coordination, cooperation and communication among foster parents, foster parent associations, child care agencies and other child advocates;
- Encourage the recruitment and retention of foster parents; and
- Inform the membership and general public of current issues.

Membership in the NFPA is open to anyone interested in improving the foster care system and enhancing the lives of children and families regarding foster care. Affiliate memberships are open to local or state foster parent associations, local or state agencies, social workers, foster parents and all other individuals interested in the foster care program. The NFPA provides an annual education conference, a quarterly newsletter, a speaker's bureau, scholarships, awards, legislative input, online resources and a variety of other activities to help and inform people who are involved in the foster care system.

❖ More information may be found at <http://www.nfpaonline.org/>

- **The Kentucky Foster and Adoptive Parent Training Support Network**

The Network, as it is generally called, is sponsored by the Department of Community Based Services and is made up of 16 teams throughout the state whose primary objective is to offer training and free, confidential peer support by parents for parents.



Each team has four to five experienced foster parents who are available to answer questions, to offer a listening ear from people who have “been there”, and to offer one-on-one and group training. Teams also generally have a community resource specialist who can offer information about local services and providers. DCBS staff and other community partners assist teams and help with coordination of activities and provision of up-to-date policy information.

Parents are trained to provide short-term crisis intervention for other foster parents in times of stress, frustration and difficulty. The Network can be especially helpful when a foster home is going through a child protective services investigation. The overall goal is to help retain good parents and minimize placement disruptions.

❖ For contact information in your service region, please call 1-877-994-9970.

- **The Foster Parent Mentor Program**



The Foster Parent Mentor Program is part of the University of Kentucky's Training Resource Center's family of programs sponsored by Kentucky's Department for Community Based Services. The program specializes in one-on-one, short-term, intensive coaching relationships, which provide newly approved foster parents

emotional encouragement, skill reinforcement, and parenting strategies unique to foster parenting so as to enhance the quality of care provided and stabilize initial placements. Upon completion of the required preservice training, the Foster Parent Mentor Program will match you with a veteran foster parent in your area that will make a weekly contact with you for a period of six months.

During this mentoring period, participants will share practical pointers on the day-to-day workings of out-of-home care. Your mentor will also be available to help you when questions, concerns or crises arise.

- ❖ Program Coordinator Contact Information: (866) 440-6376
- ❖ Find our more on the web at www.uky.edu/trc/fpmentor

- **Adoption Support for Kentucky (ASK)**

Adoption Support for Kentucky (ASK) is part of the University of Kentucky's Training Resource Center's family of programs sponsored by Kentucky's Department of Community Based Services. ASK specializes in the utilization



of support groups to offer pre and post-adoptive support and services to foster parents. Group meetings provide the opportunity to share resources, suggestions, frustrations and successes with those who share the unique life experience of adoption.

ASK strives to prevent pre-adoptive disruptions and post-adoptive dissolutions through peer support and training.

The groups are open to any family formed through adoption — at any stage in the process. You may choose to adopt through the state, privately, internationally or through kinship care, or you may simply be considering adoption. Regardless of the type of adoption or stage in the process, ASK is here for you.

The groups are facilitated by an adoptive parent who understands the needs, joys and challenges of an adoptive family. ASK also offers mentoring with an experienced adoptive family, information on policies and procedures, educational/training programs, statewide resource referral and advocacy assistance.

- ❖ Program Coordinator Contact Information: (877) 440-6376
- ❖ Find our more on the web at www.uky.edu/trc/ask

- **S.A.F.E. Special Advocates For Education**

The Special Advocates For Education program is part of the University of Kentucky's Training Resource Center's family of programs sponsored by Kentucky's Department of Community Based Services. The program team members specialize in facilitating positive engagements with schools in an effort to improve outcomes for foster and adoptive children through individualized educational resources and school specific information.



- ❖ Program Coordinator Contact Information: (877) 440-6376
- ❖ Find our more on the web at www.uky.edu/trc/SAFE

- **F.A.S.Track**

F.A.S.Track is an official DCBS publication and is published periodically in collaboration with the University of Kentucky Training Resource Center Foster Parent Training Program.

F.A.S. Track

Foster/Adoptive Support and Training Programs

F.A.S.Track includes articles from specific support programs such as the Foster Parent Mentor Program, Kentucky Foster and Adoptive Parent Training Support Network, Adoption Support for Kentucky and Kentucky Foster/Adoptive Care Association. There is also information related to adoption, medically complex parenting, youth in foster care, and children from the Special Needs Adoption Program (SNAP).

- ❖ See the latest issue on the web at www.uky.edu/trc/fastrack



WHAT CAN YOU CONSENT TO AS A FOSTER PARENT?

When DCBS has legal custody of a child placed in your home, administrative laws and policies stipulate who can consent to activities for foster children.

You may:

- Assist the child's SSW by enrolling the child in school;
- Assist in making education decisions for the child upon written approval by the child's birth parent(s);
- Provide reasons for a child being absent from school to appropriate school personnel; and

- State foster parents can authorize medical treatment only in emergency situations when the worker, parent or judge cannot be reached.

Some of the items below will require SSW approval, birth parent approval, team approval or a court order. Please contact your SSW when these situations apply.

Note: Do not sign any forms promising to pay any bills or pay for any medical care.

- Participation in extracurricular activities;
- Routine medical/dental checkups;
- Short-term inter-county travel;
- Application for worker's permit and releases;
- Screening test for developmental disabilities;
- Mental health assessments;
- Participation in outdoor school programs involving overnight stays;
- Psychiatric/psychological evaluation or outpatient treatment;
- Photographs taken for publicity purposes or media promotions;
- Emergency routine surgery or major medical testing/procedures;
- Enlistment in armed forces or Job Corps;
- Marriage;
- Registration in special schools;
- Application for driver's training permit and license;
- Interstate/international travel;
- Examination by law enforcement; or
- Religious ceremonies (i.e., baptism, confirmation)

IMPORTANT QUESTIONS TO ASK AT PLACEMENT

Here are some important questions to ask when you are contacted to accept the placement of a child in foster care:

The Basics

- What is the child's name?
 - How old is the child?
 - What sex is the child?
 - What is the child's religion?
 - Are there any cultural needs or considerations?
 - Are there any linguistic needs?
 - Are there any likes or dislikes?

Siblings

- Does the child have siblings?
- Are they in the custody of the Cabinet?
- If so, where? Are there visits with siblings?

- How often do the visits occur?
- Where will they take place?
- Who is expected to provide transportation?

Health Concerns

- Does the child have any medical conditions?
- Will I need training regarding how to care for these conditions?
- Does the child have any allergies?
- Is the child on any medications? If yes, what?
- Are there any special dietary concerns?
- Are there any medical records? If not, who can the pediatrician contact to get such records?
- Does the child have a Medical Card?



Education Needs

- Have any/all arrangements been made for the child to start school?
- Have records been transferred?
- Is there an Individual Education Plan (IEP) in place?
- Are there any special arrangements necessary for the child's education?
- Is the child involved in any extracurricular activities at school?

Emotional Considerations

- Does the child receive any therapy or counseling? If so, what kind?
- How often are the sessions? Where do they take place?
- Who is expected to provide transportation?
- Has this child been sexually and/or physically abused?
- If so, does the child exhibit behaviors (i.e. act out) as a result of this abuse?
- Does the child have any fears (i.e., cats, dogs, the dark)?
- Are there any behavioral issues?

Developmental Concerns

- Is the child developmentally on schedule? If not, explain.
- Is there a history of violence, drug or alcohol use?
- Is the child sexually active?

Family History

- What visitation schedule has been established?
- How often do the visits occur?
- Where will they take place?
- Who is expected to provide transportation?
- If the birth parents have more children, will I be called to take them?

- Does the child require any religious instructions?
- If so, where? When? Who is expected to provide transportation?

DCBS Involvement

- When was the child brought into foster care?
- Was the child previously in foster care?
- How many placements has he/she had?
- Is there a current case plan? If yes, will you bring a copy with the child? If no, when is the first case planning conference?
- Who is the social worker?
- What is the social worker's telephone number?
- What is the social worker's After Hours contact information?
- Who is the supervisor? What is the supervisor's telephone number?
- What is the supervisor's After Hours contact information?
- Who is the child's attorney (guardian ad litem)?
- Is the child coming from another foster home?
- Why is the child being removed from that home?
- May I contact the former foster parents concerning the child?
- What is the per diem for this child?
- When will I receive the first payment?
- What is the permanency plan for the child?
- What is the anticipated length of stay for this child?
- Does the child have clothing or any other belongings with him/her?
- Is there anything special I should know about this child?
- Is a car seat or booster seat available, if needed?

Please keep in mind that the R&C or SSW will probably not have the answers to all of these questions at the time of placement, but should provide you with the information as soon as it becomes available to them. There are some instances when the SSW doesn't have any of this information. In cases where children are abandoned, even the most basic information, like the child's name, may not be known. As information becomes available it should be shared with you and vice versa. Don't hesitate to call the SSW when you have questions.

DISASTER PLANNING

Disaster can strike quickly and without warning. It can force you to evacuate or confine you to your home. What would your family do if you didn't have water, gas, electricity, or telephones? Help will be on its way, but might not reach you for days. Disasters can be frightening for adults, but may be particularly traumatic for children. Children depend on their routine and will look to their parents or caregiver in time of emergency for a sense that things will be okay. Knowing what to do is your best protection against disaster and also your responsibility to your family. Families will make it through a disaster if they work together as a team and take time to prepare for different events that could happen. Your family should prepare a Family Disaster Plan together and practice every six months to help everyone remember what to do in case of an emergency.

If you have a **child with special needs**, you should make plans before a disaster for where and how you will evacuate. Many communities have “special needs shelters” that are equipped with medical staff and specialized equipment. Call your local Red Cross office to find out about their policies and procedures for helping you and your family in case of an emergency.

To prepare a plan for your children and family in the event of a disaster, please refer to the “Disaster Preparedness Handbook for Families and Children” at the link below.

<http://chfs.ky.gov/NR/rdonlyres/7052B820-4EEF-41B3-8183-DE1534150595/153150/DisasterPreparednessBooklet.pdf>

Please Note: The link above will attempt to download an Adobe PDF. If it returns the message “Link Not Found”, please copy and paste the link directly into your browser’s address field and connect as if it were a typical web site.

NUMBER OF CHILDREN FOSTER PARENTS MAY CARE FOR

The number of children foster parents may care for depends on the approval level of the foster home. Foster home approval levels are Basic, Advanced, Care Plus, Advanced Care Plus, Medically Complex, Advanced Medically Complex, Degreed Medically Complex and Specialized Medically Complex. Below are the guidelines regarding the number of children a foster home may care for:

- No more than five (5) children (including children under the custodial control of the Cabinet and the parent’s own children living at home), are to reside in a foster home.
- No more than two (2) children under age two (2) (including children placed in out-of-home care by the Cabinet and the parent’s own children), may reside at the same time in a foster home.
 - A **Medically Complex** home provides care for:
 - No more than one (1) medically complex child can reside in a one-parent medically Complex foster home;
 - No more than two (2) medically complex children can reside in a two-parent medically complex foster home; and
 - No more than four (4) children, including the medically complex foster home’s own children, reside in a medically complex home unless:
 - An exception is granted as required in SOP; and
 - The medically complex foster home has daily support staff to meet the needs of the medically complex child.
 - A **Care Plus** foster home provides care for:
 - No more than one (1) care plus child in a one-parent care plus foster home;



- No more than two (2) Care Plus children in a two-parent cre plus foster home;
- No more than four (4) children, including the care plus foster home's own children, reside in a Care Plus foster home unless;
 - An exception is granted as required in SOP; and
 - The care plus foster home has daily support staff to meet the needs of the care plus child.

CONCERNS/COMPLAINT PROTOCOL

When a policy question or procedure clarification is needed or if you have a concern or complaint, please follow the below protocol:

1. Check with your child's social services worker. The SSW may need to seek assistance to answer your question or concern so you may not get an answer right away.
2. Go to the supervisor. This step should be used only after you have approached your worker. Reasons to seek the supervisor would be that you have received no answer from the SSW or you do not feel confident that the answer you were given is correct. If you still do not feel that your concerns have been addressed you may proceed to the next level.
3. Contact the next level supervisor as identified by your SSW. Some regions have designated complaint specialists.
4. Contact your Service Region Administrator (SRA), or designee as identified by your SSW.
5. You can contact Central Office staff to provide technical assistance.

It is our hope that if you are following the chain of command, it would rarely reach the point where you would need to contact Central Office directly as someone along the line will either answer your question or will be contacting Central Office for clarification themselves.

MAINTENANCE- FOSTER HOME REIMBURSEMENTS

The SSW specifies the daily rate (per diem) for care of a child placed in the foster home. The foster home rate structure is designed to give foster parents flexibility and autonomy to decide how to spend money for the children in their homes. R&C worker approval is not necessary for services included in the per diem. Reimbursements occur through debit cards or direct deposit.

The SSW ensures that a DPP-111A Foster Home Contract Supplement is provided to the foster parent(s) upon the foster home's acceptance of a child. The FSOS or designee signs the completed DPP-111A, including any known history and risk factors regarding the child being placed and the SSW obtains the signature of the foster home's parent(s). Sometimes it is not feasible to have the form signed at the time of placement. In those instances, the DPP-111A is signed within three working days of placement. As with any other type of substitute care placement, the SSW is to inform the foster parent of any history of inappropriate sexual acts or other behaviors of the child that indicates a safety risk for placement. If such information is not known at the time of placement, the SSW is mandated to inform the foster parent as soon as practical, but no later than 72 hours after receiving the information.

Foster home reimbursements are subject to change and are based upon available funding.

At the time of publication the per diem rates are as follows:

Foster homes approved as:	Basic	Advanced	Degreed
Birth to age 11	\$24.10	\$26.40	N/A
Age 12+	\$26.20	\$28.50	N/A
Care Plus Home	\$42.40	\$47.70	N/A
Medically Complex	\$42.40	\$47.70	\$50.90
Specialized Medically Complex		\$59.80	N/A
Degreed Specialized Medically Complex	N/A	\$59.80	\$97.00
Supplemental Services Rate	N/A	\$72.10	N/A

OVERPAYMENT/UNDERPAYMENT OF MAINTENANCE REIMBURSEMENTS

Sometimes an underpayment occurs and it is important for you to notify your local R&C worker and/or billing specialist immediately so the problem can be corrected. Any overpayments above the amount reflected on the signed 111A contract for the child placed in the home may be recovered by the agency. Please review your check each month for accuracy as we realize that an unexpected adjustment in your check could cause a hardship.

PROPERTY DAMAGES

Report property damages to your local R&C worker for information about filing a claim. All claims of \$1000 and above must be submitted to the home owner's insurance of the foster parent(s) prior to filing a claim.

CHILD CARE SERVICES

The child's social services worker facilitates DCBS payment of childcare services for foster parents who work outside the home. These requests for childcare services are reviewed every six (6) months.



For foster parents who do not work outside the home, the R&C worker submits a request for childcare to the SRA that includes documentation from a qualified professional of the therapeutic need for the service. The SRA conducts a special review of these approved requests quarterly. Approved child care rates cannot exceed the rates established by the Division of Child Care.

TRAINING EXPENSE REIMBURSEMENT

Foster parents may be reimbursed for training expenses when the following conditions are met: The R&C worker authorizes reimbursement, for foster parents for mileage, babysitting of the foster child and tuition or fees to assist the foster parents with meeting ongoing training requirements. The maximum reimbursement for tuition or fees to meet this goal is:

- One hundred dollars (\$100) per family per year; or
- Two hundred dollars (\$200) per year for an Advanced, Medically Complex or Care Plus foster home.

Note: All requests for foster parent training expenses must be pre- approved by the R&C FSOS, and an approval memo copied to the Regional Billing Clerk. This does not apply to adoption-only parents.

The R&C worker authorizes reimbursement for foster parents' mileage and babysitting of foster children, to facilitate their attendance in local and state foster care association meetings or training.

RESPITE CARE FOR BASIC/ADVANCED/CARE PLUS/MEDICALLY COMPLEX FOSTER HOMES

Respite care is offered to foster parents to provide relief in meeting the extraordinary demands of children in out-of-home care. All foster parents are eligible for one day of respite care per child, per month, which is included in the per diem. For the convenience of the foster parents, the one day of respite may be used as a twenty-four (24) hour period of time or divided into hourly portions.

Foster parents caring for children designated as **care plus** are eligible for two (2) additional days of respite care per child per month.

Foster home parents caring for children designated as **medically complex** are eligible for two (2) additional days of respite care per child per month.

Foster home parents caring for children designated as **specialized medically complex** are eligible for three (3) additional days of respite care per child per month.

Respite care is reimbursed to the foster parents at the per diem rate of the child and may not exceed the per diem rate established.

Foster parents are responsible for paying their respite providers.

RESPITE PROVIDER REQUIREMENTS

When selecting a respite care provider, it is critical for foster parents to understand the requirements respite providers must meet to provide care for children placed in their home. Below is a breakdown of the requirements a respite provider must meet if the provider is not an approved foster/adoptive home:

Basic Homes: If a foster parent selects a respite provider who provides respite care in the foster home, but is not an approved foster home parent, the R&C worker must ensure that the chosen provider meets the qualifications below before the home can be utilized for respite in the foster parent's home:

- Successful completion of the 2-hour Respite Provider Training;
- Provides proof of United States citizenship or legal immigrant status;
- Completes background checks required for foster parents;
- Reads and signs the discipline policy form;
- Completes a confidentiality form; and
- Receives child specific training

If a foster parent selects a respite provider who provides respite care outside the foster home but is not an approved foster home parent, the R&C worker:

- Ensures successful completion of the 2 hour Respite Provider Training;
- Requires proof of the provider’s United States citizenship or legal immigrant status;
- Completes background checks required for foster parents;
- Reads and signs the discipline policy form;
- Completes a confidentiality form; and
- Completes a home environment assessment to ensure compliance with SOP 12.13, “Home Environment Prerequisites”; and
- Receives child/condition specific training

For Care Plus foster homes, the R&C worker verifies that the respite provider meets the above requirements for basic homes and additional requirements including the following:

- Ensures successful completion of the 2-hour Respite Provider Training;
- Receives child specific training from the foster parent or child’s mental health provider.

For **Medically Complex** Foster Homes, the R&C worker verifies that the respite provider meets the above requirements, and additional requirements including the following:

- Ensures successful completion of the 2-hour Respite Provider Training
- Receives child/condition specific training;
- Holds current certification in CPR for infants, children and adults; and
- Has completed a Certified First Aid training.

A foster parent may have a respite provider accompany them to Join Hands Together to meet the Cabinet approved training requirement above. Please note that if the training schedule requires lodging and meals the respite provider will be responsible for their own expenses.

A health screening is required for all adult and dependent children residing in the home providing respite.

If necessary, a respite provider will be asked to contribute to a child’s medically complex monthly report (form DPP-104C).

TRANSPORTATION EXPENSES

Non-medical transportation expenses for foster parents are rolled in to the daily per diem rates. Extraordinary transportation reimbursement may be considered on a case by case basis; however, this applies only after a foster home can justify that the transportation allowance in the per diem has been exhausted.

The SSW or R&C Worker and DCBS foster parent may utilize the Non-Medical Transportation Calculator for DCBS foster parents when a transportation request is being considered and the monthly mileage has been exhausted. For example, given a .40 mileage rate for state employees, a foster parent providing basic foster care to a child under the age of 12 would exhaust the mileage included in the per diem at 241 miles. All other non-medical transportation is included in the per diem. The “Non-Medical Transportation Calculator for DCBS Foster Parents” spreadsheet may be viewed at:

<http://manuals.sp.chfs.ky.gov/Resources/Related%20Resources%20Library/Non-Medical%20Transportation%20Calculator%20for%20DCBS%20Foster%20Parents.xls>

Please Note: The link above will attempt to download an Excel spreadsheet. If it returns the message “Link Not Found”, please copy and paste the link directly into your browser’s address field and connect as if it were a typical web site.

For all children receiving Medicaid, the cost of non-emergency medical transportation is supported by the Department of Medicaid Services, either through the regional transportation broker or managed care provider.

To arrange for medical transportation, the R&C worker provides the foster parent with the central office medical transportation liaison’s contact information.

The medical transportation liaison assists and facilitates the process for a foster parent to be approved as a medical transportation provider through the Department of Medicaid Services, Office of Transportation Delivery and regional transportation brokers.

Upon approval as a medical transportation provider, the liaison advises the foster parent of the required documentation to receive reimbursement for transportation provided to children in their care for medical appointments.

CLOTHING ALLOWANCE

Foster parents are issued an initial clothing allowance for children placed in their home. At the time of publication, clothing allowances issued to foster parents will not exceed the following amounts:

Child’s Age	Amount
Birth to 1 year of age	\$100
1 to 2 years of age	\$120
3 to 4 years of age	\$130
5 to 11 years of age	\$180
12 + years of age	\$290

If a child is moved from one foster home to another foster home, upon request of the child’s SSW, the billing specialist issues the balance of the child’s unspent initial clothing allowance by authorizing a special payment to the child’s placement provider at such time the need arises.

An annual supplemental school clothing allowance (see table below) is issued to a child age 3 or older, who:

- Has been in care more than 30 days;
- Has used the amount allotted for clothing allowance;
- Is enrolled in school; and
- Is placed in a DCBS foster home.

Supplemental School Clothing Allowance (at the time of publication)	
Child Ages 3-10	\$50
Child Ages 11+	\$100

The foster parent’s R&C worker reviews the foster parent’s clothing record quarterly.

Clothing expenses include children’s apparel such as diapers, shirts, pants, dresses, suits, footwear, belts, and clothing services such as dry cleaning, repair and alterations, and storage. **Ongoing monthly expenses for clothing, a child’s allowance and incidentals are included in the per diem.**

At the time of publication, the following chart shows the minimum to be spent on a monthly basis for clothing, diapers, incidentals and a child’s allowance:

Child’s Age	Clothing	Incidentals	Allowance
0-2	\$25	\$6	N/A
3-4	\$30	\$5	\$1
5-11	\$35	\$5	\$7.50
12+	\$40	\$10	\$20

Special purchases above and beyond the per diem and initial clothing allowance, up to \$250 may be approved under special circumstances. (For example, if a child loses or Gains a substantial amount of weight requiring all new clothing.)

TAXES

Many foster parents are eligible for tax credits worth, in some cases, several thousand dollars if they have adopted a special needs child. Please refer to “Kentucky’s Adoption Assistance Handbook” for additional information. **Foster families should meet with a tax advisor or the IRS to discuss which tax benefits may apply.**

Please note: payments you receive for providing care to children in foster care should be considered as reimbursement for the care of the child and not income.

MEDICAL TREATMENT AUTHORIZATION, REQUIRED MEDICAL TREATMENT AND THE MEDICAL PASSPORT

Assuring that the health needs of children in out-of-home care are met is a major responsibility for you and the child’s social services worker. Foster parents are to cooperate with the Cabinet in medical and dental care planning:

Children in care are required to have an initial health screening within 48 hours of placement and a health exam scheduled within two weeks of placement.

In addition, children are required to have an annual dental, hearing and vision screening.

Children are also required to have a mental health screening within 90 days of placement.

Foster parents will be responsible for scheduling medical appointments and assisting DCBS in transporting a child to the doctor. It is critical that foster parents communicate



with and involve birth parents in their child(ren)'s medical care. It is important for you to know as a foster parent you can only authorize emergency medical care and only when the child's social services worker, FSOS or parent cannot be reached. It is also important for you to report all encounters with medical providers and any corrective or follow-up medical or dental care the child needs to child's SSW.

MEDICAL AUTHORIZATION

The 106A form, titled "Cabinet for Health and Family Services Authorization for Routine Health Care and Authorization for Non-Routine Health Care" is utilized to authorize medical treatment to assure that a child in care receives prompt medical attention. The child's worker provides a copy of the 106A form to the foster parent upon the child's entry into the home. The form contains the worker and birth parent(s) signatures. Foster parents maintain a copy of the signed 106A in the Medical Passport and provide a copy of the form to the medical provider when medical services are needed.

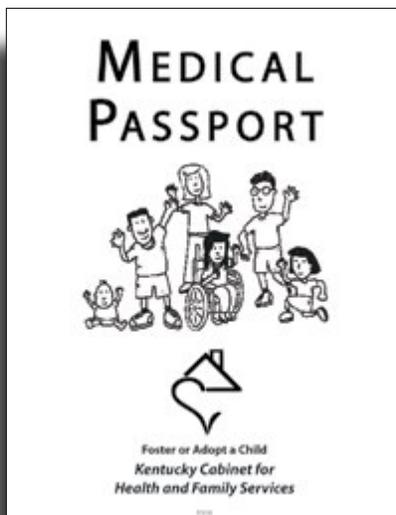
The DPP 106A contains the following information:

- A definition of routine health care,
- A statement naming the child and attesting to the Cabinet's authority to provide routine health care,
- A definition of non-routine health care,
- Instructions to guide medical providers as to who may authorize non-routine health care,
- County contact information for medical providers to use to obtain authorization to treat a child/youth, and
- Parent and Worker signatures.

If you have questions about the use of the DPP-106A form or are in doubt as to whether a medical need is routine or non-routine, contact the child's social service worker or their supervisor for that determination.

The foster parent may authorize treatment only in an emergency, when a child needs medical treatment and the SSW or Family Services Office Supervisor (FSOS) cannot be located.

MEDICAL PASSPORT INTRODUCTION



The Medical Passport was developed to serve as a repository to organize a child's medical information. It has been designed to be used for all children in out-of-home care, including medically complex children, who are placed in foster homes, private child care facilities, psychiatric and medical settings.

It is given to the care provider at the time the child is placed. The Medical Passport must be maintained continuously throughout placement and accompany the child as long as the child remains in out-of-home care.

- Why is the Medical Passport so important?
 - It ensures that all pertinent information pertaining to a child's health care is kept in one place. This

benefits the child in providing timely service when basic medical records are needed at a moment's notice for medical care and emergencies or events such as case review, court, school enrollment, day care enrollment and treatment planning conferences, etc.

- o Continuity of medical care is provided.
 - o State law requires that all children in out of home care receive regular medical care. State and federal law require the documentation of this care.
 - o Care Provider Liability - Lack of documentation is equal to lack of services. In other words, **“If you don’t write it down, it didn’t happen!”** The Medical Passport documentation provides verification that this medical care is taking place.
 - o A child’s needs and history are more easily explained to birth parents and other care providers upon changes in placement or changes of social services workers.
- How do I use this Medical Passport?

SOP states that foster parents are to maintain “the medical passport with all medical information relating to the health history and ongoing medical care of the child”. If the child will be accompanied to the appointment or exam by a social services worker or transportation aid in lieu of the care provider, then the social services worker or care provider will assume responsibility for the Medical Passport binder and its contents, share it with the medical professional, and ensure that all forms are completed. Care providers should not assign these responsibilities to the child in the care provider’s absence. The Medical Passport includes tabs that are designed to be used with the three-ring binder. Each child should have his/her own binder, even if siblings reside in the same foster home. Each tab section includes instructions on how to utilize the forms for that section. Other helpful hints are also included.

MEDICAL PASSPORT FORMS

There are a number of forms available to record routine and non-routine health care.

- “Cabinet for Health and Family Services Authorization for Routine Health Care and Authorization for Non-Routine Health Care” DPP-106A
- “Initial Physical and Behavioral Health History” DPP-106B
- “Medical Appointment” DPP-106D
- “Dental Care” DPP-106E
- “Visual Screening” DPP-106F
- “Mental Health Services” DPP-106G
- “Prescription and OTC Medication Administration” DPP-106H
- “Methamphetamine Exposure Medical Evaluation and Follow-up” DPP-106I
- “Medication Transfer Form” DPP-106J

DPP-106 Forms A through H (C is not currently used) will be used at some point during the child’s stay in out-of-home care. If you run out of forms or the child’s Medical Passport did not have a particular form to begin with, request them from the child’s social services worker and be persistent. A blank copy of Prescription and OTC Medication Administration (DPP-106H) should be kept from which to make copies as needed. A blank Methamphetamine Exposure Medical Evaluation and Follow-up form

(DPP-106 I) is not included in this Medical Passport which is to be completed by a social services worker at the time of a child's medical evaluation. The social services worker completes the form because the initial evaluation is to take place two to four hours after a child's removal from the Methamphetamine environment.

It is very difficult to get forms filled out by medical professionals a few days or weeks after the appointment. Not having blank forms is no excuse for failing to include them in the Medical Passport. Photo copies of blank forms may be used. If photocopied forms are used, additional copies must be made for the case file once the forms are completed. If a Cabinet approved form is not available at the time of an appointment, ask for a copy of the form the medical provider used to record the care provided.

Remember "If it's not written down it didn't happen."

HOW ARE COPIES OF THE FORMS DISTRIBUTED?

Medical Passport forms are either a single page or composed of carbonless paper forms with white and yellow copies.

Once completed, the white copy or the original is to be kept in the Medical Passport binder. A photo copy or the yellow carbonless copy is to be given to the child's social services worker to notify him/her of the medical status of the child and is to be kept in the child's case record. Photo copies or the yellow copies of medical, dental, and visual screening forms should be given to the child's social services worker within one week of the appointment. Photo copies or the yellow copies of medication forms should be given to the child's social services worker at the end of each month.

Medical Passport forms in the child's case file must be available for review by many service professionals. Medical professionals are encouraged to write legibly and press firmly. If you have a yellow copy and it cannot be read, please give the social services worker a photo copy of the white original for the case file.

Do not allow the medical professional to keep the original completed forms. Encourage them to make photo copies and return the originals and carbons, if applicable, for Medical Passport use. You may also want to make copies of completed forms for activities such as day care, school and camp registration/enrollment. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

MEDICATION MANAGEMENT

Foster parents are to give a child's prescribed medications only with a physician's prescription or authorization, and are to dispense the exact amount of any medication prescribed for a child by a physician or dentist and may not stop medication without a physician's orders. The foster parent documents administration of medication to the child and daily documentation of the medication's administration on the DPP-106H Medication Administration History form (found in the Medical Passport). Due to the potential severity of any adverse reaction, ALL medication (over-the-counter and prescription) are to be documented. Foster parents are to inform the agency within one (1) working day of any psychotropic medication prescribed for a child.

MEDICATION ADMINISTRATION TRAINING/FIRST AID

The Council on Accreditation requires all foster parents to be educated on medication administration and (non-certified) first aid. Online trainings have been added to TRIS

to provide these trainings. New foster parents must complete these trainings as part of the preservice training process. Please note, foster homes designated as medically complex homes must hold a current certification in CPR for infants, children and adults and complete certified first aid training.

The medication administration online training is titled Medication Administration Training. The Cabinet approved first aid online training is titled Non-Certified Basic First Aid Skills. The web site to access these trainings is:

<http://www.training.eku.edu/rpwebbasedtrg.htm>

To log in to the Web Based Trainings (WBT) your

- username will be your first name then a dot then your last name, all with no spaces like this - robert.jones.
- password, if it is your first time logging in, use the last four digits of your SSN. You will be prompted to change your password when you log in the first time.

If you have any problems with or further questions about WBTs call the TRIS Office at 859-622-2332. You may also contact your R&C worker.

MEDICAL CARD

Each child entering care has their own medical insurance. The majority will have a medical card. A small number will be covered under a birth parent's insurance. The child's SSW will ensure you receive the proper card.

EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

Foster parents should be aware that Children under five (5) are to receive an Early Periodic Screening, Diagnosis, and Treatment Services (EPSDT) screening from the local health department or, if eligible, a First Steps screening (federal zero to three program) as a substitute for a mental health screening.

A child in foster care who is eligible for Medicaid is also eligible for EPSDT services, such as: Immunizations; Hearing tests; Vision tests; Physical health examination; and other services for early detection of conditions and provisions of routine well child care. The child may also be eligible for EPSDT special services, which are not routinely covered by Medicaid, but are medically necessary and preauthorized by Medicaid. For example, if a provider can demonstrate medical necessity for unique durable medical equipment, EPSDT Special Services may cover its cost.

WIC: WOMEN, INFANTS AND CHILDREN

The Women, Infants and Children (WIC) Supplemental Nutrition Program is a federally-funded health and nutrition program for women who are pregnant, breast feeding, or just had a baby; and children under 5 years old (including most foster children).

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a short-term intervention program designed to influence lifetime nutrition and health behavior in high-risk populations. WIC is funded by the United States Department of Agriculture.

WIC provides nutritional education including breast feeding education and promotion and vouchers for baby formula,



cereal and other nutritional foods to meet a child's individual needs. Contact the child's SSW for information about WIC.

DISCIPLINE POLICY

Upon approval as a foster parent, you will be asked to sign the DPP-1291, "Foster, Adoptive and Respite Home Discipline Policy". Please, carefully read the policy and familiarize yourself with the language, as you will be required to understand and practice these principles with children placed in your care. The policy states:

- Discipline is an essential part of caring for children. The goal and purpose of discipline is to teach a child acceptable behaviors and to replace negative behaviors with positive behaviors. Through positive discipline children should be assisted in developing the awareness and ability to control their own behavior, assume responsibilities, and make daily living decisions.
- In providing discipline, it is equally important to encourage positive, desirable behaviors as it is to correct or provide consequences for unacceptable behaviors.
- Foster home parents should recognize that most children in out-of-home care have been abused, neglected, emotionally maltreated, or sexually exploited.
- Foster home parents can expect that some children may anticipate harsh treatment based on previous life experiences and may misbehave to test the boundaries. It is not unusual for challenges to arise in providing discipline for children in out-of-home care. It is important that foster home parents consult with the R&C or child's worker and/or supervisors if they become frustrated in their discipline efforts.
- Foster home parents are to use the discipline techniques described in the preservice process. Appropriate discipline considers the age and developmental needs of the child, as well as the child's history and past experiences. It is important to establish clear guidelines, limits or "house rules", so that the expectations of the child are understood.

Foster parents may not:

- Use any form of punishment or corporal physical discipline as defined in KRS 199.896(18);
- Deny food, shelter or clothing;
- Interfere with implementation of the child's case plan;
- Deny visits or contact with family members;
- Have the child engage in extremely strenuous work or exercise; or
- Act in bizarre, severe, cruel or humiliating ways. Examples of unacceptable actions include, but are not limited to, verbal abuse, derogatory remarks to the child or about the child's family, threats of removal from the home, placing non-food or painful substances in a child's mouth to placing noxious, irritating or potentially damaging substances in the mouths or lips, whether food, or non-food.

In addition, foster parents must not use inappropriate discipline nor punish an infant or child for incessant crying, bed wetting or actions related to toilet training.

Because of the trauma inflicted upon children coming into care you must expect

demanding stressful situations, including situations not encountered with typical parenting. Be prepared to take appropriate actions to keep yourself calm while dealing with behaviors and situations foreign to you. Discuss your ideas on discipline with your worker or the child's worker and make sure the actions you plan to take are appropriate.

Foster parents must not delegate or permit discipline or punishment of a child by another child.

Separation from others or "time out" should be used with caution and should only be provided in a safe, unlocked, well-lit environment where the child can be easily observed by the foster parent. The maximum time limit should not exceed the number of minutes equal to the child's age plus one minute.

If foster parents use any prohibited form of discipline or punishment, designated Cabinet staff will complete a foster home review with the family to include recommendations for corrective action. The SRA or designee is responsible for approval of the foster home review, which may include a recommendation for closure of the foster home.

LIFEBOOKS

Foster home parents encourage family connections through their assistance in developing and maintaining lifebooks for children placed in their care. A lifebook is a significant link to the child's past and provides a collection of historical events and stories surrounding the child's family and life. A lifebook should be started within the first 30 days of a child entering out-of-home care. The lifebook will accompany the child throughout the child's placement history. A lifebook may help decrease the child's feelings of loss and separation from their family. Lifebooks are reimbursed up to \$70 for start-up costs per child. An additional \$25 per child every six months may be reimbursed for maintenance of the lifebook. Please talk to your R&C worker and the child's social service worker to locate trainings in your area for tips on developing lifebooks.

HAIRCUTS

If a foster parent has cared for a child for more than thirty (30) days or the child's parents have had their rights terminated (TPR) by the court, the foster home parent may make decisions regarding haircuts and hairstyles for foster children. The foster parent ensures with the R&C worker that the foster child does not meet special circumstances for religious or cultural exemption. For example, in Native American and certain Apostolic Christian faiths, cutting the hair may be a violation of their religious rights and cultural traditions.



TOBACCO PRODUCTS

It is against the law in Kentucky for children under the age of 18 to smoke tobacco or use tobacco products. Foster parents are not permitted to purchase tobacco products for a child in care. In addition, family members and relatives of a child committed to the custody of the Cabinet are not permitted to purchase tobacco products for the child/youth. The SSW will assist the child and the foster parent in an attempt to eventually

eliminate the child’s tobacco use. Nicotine replacement products may be purchased (by the foster parent, and reimbursed) and the SSW may seek assistance from the child’s physician. The child may participate in smoking cessation services offered by local health departments or their contracted agents at no cost.

NORMALCY FOR CHILDREN AND YOUTH IN OUT OF HOME CARE

Federal law (PL 113-183) requires all children in out of home care have the opportunity to experience a normal life. Normalcy is achieved when children and youth in care are allowed to participate in developmentally and or age appropriate activities. The Reasonable and Prudent Parent Standard has been established to help guide decision making for foster caregivers.

The term “reasonable and prudent parent standard” (RPPS) means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver must use when determining whether to allow a child in foster under the responsibility of the State to participate in extracurricular, enrichment, cultural and social activities.

Caregiver means a foster parent with whom a child in foster care has been placed or a designated official for a child care institution in which a child in foster care has been placed. All caregivers must receive training on the reasonable and prudent parent standard before applying the standard. Examples of typical activities when the reasonable and prudent parent standard may be applied, as well as non-typical activities when it may not be applied, are illustrated in the chart below.

Typical Activities	Non Typical Activities
Sleepovers	Surgery
Swimming	Birth parent and sibling visits
Dating	Court orders
Hunting	Medications- psychotropic, birth control
Riding Jet Skis	Tattoos, body piercings, etc.
Family camping outings	Return a child to a birthparent without court approval
Obtaining a driver’s license	Discipline policy
Operating power lawn mowers	

DRIVER’S LICENSE FOR YOUTH

Youth in care may apply for a driver’s license or permit when it is determined to be appropriate by the DCBS worker. The foster parent should not sign the application.

The birth parent or legal guardian may sign an application for a driver’s license for a youth under the age of 18 pursuant to KRS 186.470 – Application of Minor, however they must assume all obligations imposed by KRS 186.590 – Minor’s negligence imputed to person signing application or allowing him/her to drive. The SSW informs a youth that car insurance is required should the youth wish to apply for a driver’s license.

BABYSITTING

Foster Parents may utilize **short-term** babysitters for children placed in their care to give them time to attend medical appointments, hair appointments, go to the grocery, attend training, and for other activities as needed. Babysitters can only be used for periods of 24 hours or less and only when the reasonable and prudent parent standard is applied. Background checks, home environment requirements and medical screenings are not required.

Babysitters:

- must be age 18 or older for youth leveled 3, 4 or 5, designated as care plus or medically complex.
- for medically complex children must be certified in CPR and First Aid for adults, infants and children and receive child specific training.
- for care plus children must also receive child specific training or have training in the mental health treatment of children or their families.

SAFETY PRECAUTION

Foster parents should take safety precautions when children are placed in their home. For example, when a child is riding a bike, roller skating and ice skating the child should wear a helmet and proper clothing. Please use good judgment in these situations as you do not want allegations made regarding the safety of children in your care.

CAR SAFETY

Before transporting children who are placed in out of home care, foster parents will need to make sure they have the required car safety equipment. If you do not have this equipment, notify the child's SSW and ask for assistance. Car crashes are the leading cause of death for children from birth to age 21 (more children die in car crashes than from any disease).

The law in Kentucky:

According to the Kentucky State Police, any child who measures fewer than 40 inches tall must ride in a **car** seat. Infants must ride facing the rear in a convertible seat and must stay in the rear facing position until they weigh at least 20 lbs. and have reached at least 1 year old. If a 1-year-old baby weighs only 18 lbs., she should still stay rear facing until she reaches the 20-lb. weight, according to the Kentucky State Police. Once a baby reaches the 1-year, 20-lb. mark, she may ride in a convertible car seat in the front-facing position and stay that way until she reaches 40 lbs.



Booster seats are required for children ages one to seven who weigh between 20 and 80 lbs. Children weighing between 20 and 40 lbs. require a harness, adjusted to fit snugly against the child; no more than one finger width should fit between the child's collar bone and the harness strap, according to Drive Smart. After a child reaches 40 lbs., his parent or guardian can secure him into the booster seat with the car's safety belt instead of a harness, according to Kentucky State Police.

Wearing a seat belt represents the last stage in the process; the child will continue to wear her seat belt for the rest of her life.

“All children over seven years of age and over 50 inches tall must be secured in a seat belt,” state the Kentucky State Police. Children should ride in the backseat, which poses less of an injury risk than the front seat. According to Drive Smart, research shows that children under 12 should ride in the backseat.

EMPLOYMENT

When a youth in your care begins to seek employment, please discuss this with the youth’s SSW. Employment should not interfere with the youth’s sleep, extracurricular activities or visits with parents and siblings. Once a youth obtains employment, the SSW ensures that the youth is assisted with structuring a budget.

It is recommended that the youth spend at least fifty (50) percent of the money he earns as he chooses, and the remainder placed into savings for purchase of transportation or to meet expenses upon release from commitment. When a major expenditure (such as purchase of a car) is part of the youth’s plan, the FSOS may approve a reduction of the savings percentage.

RECREATION

Foster parents are to provide opportunities and transportation for recreational activities, which are appropriate to the age and abilities of the child, and are to encourage children to take part in community services and activities both with the family and on their own.

RELIGION

Foster parents are expected to provide the child or children with a normal life including the opportunity for a child placed in their home to attend and practice religion compatible with the child’s heritage. Permission should be obtained from the birth parents for a child to participate in any religious ceremonies (baptism, confirmation, etc.) Please contact the child’s SSW if you have questions.

TRAVEL

When planning a vacation or travel with a child in your care, please be aware that foster parents are required to notify the Cabinet one week prior for approval, if they plan to leave the state with the child or children for more than 24 hours, or if the child or children will be absent from the foster home for more than 24 hours.

The DPP-111 Foster Home Contract states that the foster parent agrees to provide the child with a “normal family life”. As such, the expectation is that a foster parent will transport a child as he would transport his own child. So, when planning a vacation or travel with a child in your care, please be aware that foster parents are required to notify the child’s Social Service Worker one week prior for approval if the child will be:

- absent from the foster home for more than 24 hours regardless of the destination or
- out of state more than 24 hours.

VISITATION - HELPING THE CHILD WITH VISITS

As a foster parent, you can assist the child in preparing for visits. Remain positive about the birth parents. Parental visits or contact can sometimes be stressful for the child.

If your child displays different behavior after a visit, phone call or reading mail, or reports something which concerns you, please share this information with the child's social services worker.

If a birth parent does not show up for a visit, again, be positive in the way this is discussed with the child, being careful not to say anything that might sound derogatory about the birth parent(s). Remember, children and birth parents experience, again and again, the grief of separation. It is very important that children maintain a connection with their birth parent and relatives in order to help them through this grief process. If the child is upset after a visit, allow them to have those feelings. Sometimes visits can be upsetting. Saying goodbye is difficult. It helps the child to know when the next visit is scheduled.



Don't conclude that it is a mistake for the foster child to visit their family. Even if it is occasionally upsetting, in general there are more advantages than disadvantages to such visits for most children. Visits help children maintain a sense of reality about their family. If something unusual happens during a visit, or if the child always returns upset or unhappy, report this to the SSW. Always report any suspected abuse.

If children are allowed to talk freely about their parents and their situation, they may feel less anxious. Answer their questions clearly, simply and sensitively if they are confused about why they are in foster care. Never promise them that it will be OK.

Children continue to love their parents no matter how they are treated or what problems the parents have. Be careful about what you say and how you say it. If you are negative about their parents, children may respond defensively, and this could have a negative effect on their self-esteem. It could also force them to take sides. It is important to be honest in acknowledging parental behavior that is not in the child's interest. Putting behavior in terms of "choices the parent made" is more objective and non blaming.

Visitation agreements are negotiated during case planning meetings and must involve parents, children and significant others who are important in the child's life. The visitation agreement specifies who can or cannot visit with the child. Participants such as grandparents, family friends and previous caregivers should be included in some visits if the child requests their presence, and it does not place the child at risk, or compromise the achievement of case planning goals.

Visits are scheduled no less than once every two weeks with parents and no less than once every four weeks with siblings (it is desirable for siblings, when age appropriate, to have some visits separate from parents and if at all possible more frequent visitation). This is a minimum, and more frequent visitation is recommended for infants (two to three times a week) and very young children to facilitate positive attachment.

Every effort is made to schedule a visit at least once a week. The length of the visits should give the parent and child sufficient time to interact and practice skills as well as work on the issues that resulted in the child entering care.

Visits are no less than one hour, although the allotment of additional time is encouraged depending on the needs of the child (e.g. if the child is an infant, more time will be needed to bond).

Visits are to be held in the home or other neutral location. Unless otherwise ordered by the court, approval by the SRA (or designee) is required to hold visits in the office.

VISITS WITH THE CHILD'S WORKER IN YOUR HOME

When a child is placed in a foster home, the child's SSW is required to have a private, face-to-face visit with the child within 10 calendar days of placement and phone contact to the child within five calendar days of placement. Thereafter, the child's SSW will visit with the child at least once every 30 calendar days. During the visit the child's SSW will assess progress toward case plan goals and objectives and the child's adjustment to the out of home care placement. If a child is designated as medically complex (a nurse from the Commission for Children with Special Health Care needs visits jointly with the SSW) or care plus, the child's SSW will visit twice a month with one visit occurring in the foster home.

PHONE CALLS AND MAIL

The foster parent(s) supports and promotes family connections for children in their care including the involvement of fathers and their family members. Attachment should be promoted through regular and frequent visitation with all family members, phone calls, mail and inclusion of the parent in other various activities in which the child is involved. The foster parent(s) provide positive processing of all contact (phone, visitation, etc.) with family members, including fathers. Foster parents should not open letters to and from a child in OOHC or withhold letters from a child unless requested by the child's SSW.

ENROLLING A CHILD IN SCHOOL

Within three working days of the child's placement, the child should be enrolled in school and the foster parent may assist the SSW as applicable. It is not unusual for a foster parent to enroll children in school. For first time enrollment you will need:



- Proof of the child's name and age. The 111A form "Foster Home Contract Supplement" contains this information and may suffice. Calling the school and asking what documentation the school will accept to enroll a child in care is recommended.
- A Kentucky certificate of immunization. This certificate may be provided within 14 calendar days of enrollment.
- Proof of a preventative health care examination conducted within one year prior to initial entry into the school program. If you do not have a record of an exam provide the school with the appointment information for the child's mandatory physical exam because of their entry into foster care.

All children between the ages 3 and 6 who are entering public preschool, Head Start or public school for the first time must have an eye examination by an optometrist or ophthalmologist no later than January 1 of the school year.

Another preventative health care examination is required within one year prior to entry into the 6th grade.

SYSTEM OF INTERVENTION

The Kentucky System of Interventions (KSI) is a framework for providing systematic, comprehensive services to address academic and behavioral needs for all students, preschool through grade 12. KSI is school-wide system for providing timely support to meet the needs of all children.

This system is to ensure that all students receive timely and direct interventions at the first indication they are experiencing difficulty rather than waiting until they are significantly further behind.

Kentucky law requires notification to parents and a plan of action for students in grades 3 through 8 who need interventions because they did not meet benchmarks. The same legislation requires an individual student report for 8th through 12th graders who have taken an Explore, Plan or ACT Educational Planning and Assessment System (EPAS) assessment, Computer Adaptive Placement Assessment and Support System (COMPASS), Kentucky Online Testing Program (KYOTE) or an end of course assessment and the Kentucky Performance Rating for Educational Progress (K-PREP) tests. For these students, KSI is designed to assist students, parents, and teachers to identify, assess, and remedy academic deficiencies prior to high school graduation.

For students not qualifying for services under and Individual Education Plan (IEP), the KSI can deliver the targeted help a child needs.

Your source of information for a school's KSI is the school's Student Intervention Team. They are responsible for the development of individual student plans based on the school's system of intervention.

PROVIDING EDUCATIONAL SERVICES UNDER THE INDIVIDUALS WITH DISABILITIES ACT (IDEA)

Foster parents play a unique and critical role when children placed in their care receive special education services. The child's SSW may participate in the team, but may not make educational decisions or serve as a surrogate parent for a child in the custody of the Cabinet receiving special education services.

- The child's SSW during the initial case planning conference recommends to the birth parent(s) that the foster parent be approved to co-serve as a parent with respect to making educational decision during educational meetings such as Admissions and Release Committee (ARC) meetings and Individual Education Plan IEP meetings. If the birth parent is unable to attend these meetings this will ensure that a child's educational needs are not disrupted while the child is placed in out of home care.
- In order for the foster parent to co-serve, the birth parent must grant permission in writing on the DPP 330 Educational Advocacy form. If the birth parent doesn't attend the initial case plan conference, or cannot be located, the SSW will request that the court assign the child's foster parent as the child's educational surrogate.
- Whenever the birth parent and foster parent attend an educational meeting together, the birth parent remains the primary authority to make educational decisions on behalf of the child.

HIGHER EDUCATIONAL ASSISTANCE

- **Chafee Foster Care Independent Living Program**

The Chafee Foster Care Independence Program operates to empower youth ages 14-21 who have experienced out-of-home placement, to develop their potential to become self-sufficient yet interdependent with the community and to successfully transition into adult living. If a youth placed in your care is eligible for a tuition waiver as established in KRS, KAR the youth's SSW will provide the youth in your care with the DPP-333 Tuition Waiver for Foster and Adopted Children, which is presented to the post-secondary institution.

- **Educational Training Voucher for Aged Out Youth**



Foster parents should be aware of the process for youth who are aging out of care to obtain an Educational Training Voucher, ETV.

The child's SSW, the regional Independent Living Coordinator (ILC) or the Chafee Program Administrator provides the **DPP-334 Request for Educational and Training Voucher Funds** to the eligible youth to

complete and return to the regional ILC or the Chafee Program Administrator. Please refer to the SOP manual for additional information.

TUTORING

When a child in your care is struggling in school it should be brought to the attention of the child's SSW. Contact the child's school to see if there are programs offered to assist the child. Some schools and communities provide tutoring services free of charge. If no services are available, the child's SSW may make a recommendation to seek funds for tutoring.

SCHOOL LUNCHES

All children in foster care are eligible for free lunches at school. Foster parents should inform the guidance counselor or notify the enrollment office where the child attends school. The school will provide any forms that need to be completed by the foster parent.

FIRST STEPS

First Steps is a statewide early intervention system that provides services to children with developmental disabilities from birth to age 3 and their families. First Steps is Kentucky's response to the federal Infant-Toddler Program. First Steps offers comprehensive services through a variety of community agencies and service disciplines and is administered by the Department for Public Health in the Cabinet for Health and Family Services.

- **Who Does First Steps Serve?**

First Steps serves children from birth to age 3 and their families. Child eligibility for the program is determined two ways:

- Developmental delay - A child may be eligible for services if an evaluation shows that a child is not developing typically in at least one of the following skill areas:

- communication;
- cognition;
- physical; or
- social and emotional or self-help.
- Automatic entry - A child may be eligible if he or she receives a diagnosis of physical or mental condition with high probability of resulting developmental delay, such as Down Syndrome.
- How are First Steps services provided?

First Steps is available in all Kentucky counties. Services may be provided in the home, at child development or other designated centers or in a clinical setting, depending on the needs of the child and family and the availability of services in a given area.

TYPES OF FOSTER HOMES AND ONGOING TRAINING REQUIREMENTS

Following your initial approval as a basic foster home, you may be interested in seeking additional training to be certified as a care plus or medically complex home. Discuss your interest with your R&C worker.

To be approved as a basic foster home the foster home applicant completes 15 hours of preservice training and the following required web-based trainings: Pediatric Abuse Head Trauma, Medical Passport, Non-Certified First Aid and Universal Precautions and Medicaid Administration.

In addition to the required 15 hours of preservice and the web-based trainings, 30 hours of the trainings listed below must be completed within the first two (2) years of approval:

- Child Sexual Abuse (12- hours Cabinet approved training in a group setting);
- Trauma Informed Care (12- hours Cabinet approved training in a group setting);
- Psychotropic Medication (1- hour); and
- Behavior Management (5- hours of training in a group setting).

Once a foster parent has two years of experience and has completed the 30 hours of required training, they will be approved to receive the advanced rate.

*******Please note, all currently approved homes will have until November 15, 2017 to complete these required trainings.**

To maintain approval as a basic Advanced foster home, ten (10) hours of ongoing training is required annually and must be completed by the anniversary month of original approval.

- To be approved as a **care plus** foster home:
 - The R&C worker determines whether the foster or adoptive home is interested and possesses the aptitude to provide services to a care plus child;
 - Verifies that the primary caretaker:
 - Is willing to maintain a DPP-130 Daily Record of Events (DROE) of a child's activities and behaviors;
 - Is willing and able to attend all case planning conferences;
 - Demonstrates access to available support services; and

- Coordinates designated therapeutic needs provided by community resources;
- Documents that the applicant care plus foster or adoptive parent(s) receives a certificate of completion for the twelve (12) hours of care plus training, beyond the preservice training requirement in the following topic areas:
 - Specific requirements and responsibilities of a care plus foster home;
 - Crisis intervention and behavior management;
 - De-escalation techniques;
 - Communication skills;
 - Skill development;
 - Cultural competency;
 - The dynamics of a child who has experienced sexual abuse or human trafficking; and
 - The effect of substance use, abuse or dependency by either the child or the child's biological parent;
- To maintain care plus approval, twelve (12) hours of ongoing training is required in the above topic areas and an additional ten (10) hours of cabinet-sponsored training related to knowledge or skills relevant to foster parenting.
- To be approved as **medically complex** foster home:
 - The R&C worker determines whether the applicant home has the aptitude and desire to provide medically complex fragile foster care services and is able to care for a child in the custody of the cabinet who is determined to be medically due to:
 - Significant medically oriented care needs related to a serious illness or condition diagnosed by a health professional that may become unstable or change abruptly, resulting in a life-threatening event;
 - A chronic condition that is expected to be life-long and progressive and to require extensive services;
 - An acute, time-limited condition requiring additional oversight; or
 - A severe disability that requires the routine use of medical devices or assistive technology to compensate for the loss of a vital body function needed to participate in activities of daily living and significant and sustained care to avert death or further disability.
 - The R&C worker verifies that the primary caretaker in the applicant medically complex foster or adoptive home is not employed outside the home unless it is determined that the child's needs will continue to be met and an exception is approved by the director of Protection and Permanency.
 - The foster home completes the initial medically complex fragile Join Hands Together training (12 hours of training) offered by the Cabinet which covers the following topic areas specific to children with medical complexity:
 - Growth and development;
 - An overview of procedures and techniques which may be utilized to provide care;
 - Observation and assessment;
 - Management and diet and environment;

- Documentation of provided care;
 - Parenting skills;
 - Permanency planning; and
 - Obtain certification in infant, child and adult CPR and first aid and complete an online orientation.
- In addition to the training the applicant medically fragile complex foster home needs to be located within one hour of a medical hospital with an emergency room and 30 minutes of a local medical facility.
 - To maintain the medically complex designation an approved home must complete twelve (12) hours of ongoing training annually and an additional ten (10) hours of cabinet-sponsored training related to knowledge or skills relevant to foster parenting and maintain certification in CPR and First Aid.
 - Two conference style Cabinet Sponsored trainings are held each calendar year to help medically complex homes meet their training requirements. In rare circumstances, an individualized curriculum may be developed for a Foster or Adoptive Parent who is unable to participate in annual group training because of employment or other circumstances.
 - Professional experience related to the care of a child with medical complexity may substitute for the initial and annual medically complex training requirements if approved by designated cabinet staff and the foster or Adoptive Parent:
 - Is a health professional;
 - Is certified in infant, child and adult CPR and First Aid; and
 - Has completed twelve (12) hours of continuing education focusing on pediatrics within the past year that will assist the parent in the care of a child with medical complexity.

ANNUAL RE-EVALUATION/RE-CERTIFICATION

Once approved, a foster parent's home certification is good for one year. During the following year and proceeding years, foster parents will be required to complete an annual re-evaluation. The home's R&C worker will be responsible for completing the re-evaluation. To be re-approved, foster parents are required to complete ongoing training, complete a health screening by utilizing the DPP-107, Health Information form, undergo background checks and complete home environment checks.

ON-GOING TRAINING

A foster parent's ongoing training requirements will depend on the foster home's approval level (basic, care plus or medically complex) as outlined under "Types of Foster homes" on pages 38 and 39 in this handbook.

The Cabinet may provide training or training may be provided through community partners, such as colleges and universities, adult education centers, comprehensive care centers, county agencies, hospitals and libraries.

At least 50 percent of all training must be in a group setting. One on one training provided by an Adoption Support for Kentucky (ASK) or Kentucky Foster and Adoptive Parent Training Support Network instructor using a DCBS approved curriculum is included as a group setting.

There are several online trainings. You may hear these referred to as web based

trainings (WBT).

Here is a list of WBT on the ECU TRIS web site.

- Medical Passport;
- Medication Administration;
- Non-certified Basic First Aid Skills;
- Pediatric Abusive Head Trauma;
- Psychotropic Medications;
- Understanding Substance Use Disorders in Kentucky Families; and
- As a prerequisite for Medically Complex training: Medically Complex Orientation

New trainings are being developed so check with your R&C worker or go on line at:

<http://www.training.eku.edu/rpwebbasedtrg.htm>

Non-group trainings may include:

- Attendance at workshops or course work receiving prior approval of the FSOS;
- Participation in support groups or other associations related to foster care and adoption and approved in advance by the FSOS;
- Individualized professional training in the field from which the child needs specialized care, with prior approval of the FSOS;
- Workshops that are relevant to foster care or adoption, provided proof of attendance is given to the R&C worker;
- Sessions with a doctor, therapist, school or other professional to learn a specific skill, provided families provide a signed statement from the individual who provided the training indicating the skill that was taught and the time spent;
- Those necessary to maintain certifications for CPR and first aid as required for medically complex and specialized medically complex foster homes;
- College courses that are relevant to foster care or adoption, provided the foster home parent provides a copy of their final grade for the course;
- Credit for learning courses related to foster/adoptive children and parenting;
- Training tapes (audio & video) or internet training on a topic relevant to foster care or adoption, provided the foster home parent provides a written report or summary;
- Tapes from previously held DBCS approved training events, provided the foster home parent provides a written report or summary;
- Books, that are non-fiction, on topics relevant to foster care or adoption, and are 180 pages or more, provided the foster home parent provides a written report or oral summary can generate three hours of training credit.

A FINAL NOTE ON TRAINING

To define annual, a foster parent's "year" begins the first day of the month of their original approval as a basic foster parent. Their year ends on the last day of their approval month. For example, if you were approved as a foster parent on March 5th of a year then you have until March 31st of the next year to meet your on-going training requirements.

BUT...

Please do not wait until the last 30 days of your “year” to get your ongoing training. Your on-going training needs to be completed and registered before the last day of your anniversary month. Time is needed to process your attendance and completion of a training.



There are many opportunities for you to get the required training hours and the biggest advantage of starting early is being able to pick topics that are timely and relevant to you and the children in your home.

FOSTER HOME REVIEWS

When significant changes or problems occur in a foster home, the home’s R&C worker completes a foster home review. The review is completed to evaluate and assess the impact of the change on the family and to develop a plan of corrective action when appropriate. A foster home review is completed in the following situations:

- A foster parent’s ability to provide care for a DCBS child due to a sudden onset of a health condition;
- A family member dies; A family member becomes disabled;
- Change in marital status: When an approved foster parent marries, within six months the new spouse meets the requirements to be approved as a foster parent, per SOP 12.5 Preservice Training Requirements for Foster and Adoptive Parent Applicants, in order for the home to remain open;
- Loss of income or a substantial and sudden decrease in income;
- Birth of a child;
- Use of a prohibited form of discipline or punishment, which includes:
 - Corporal punishment inflicted in any manner;
 - Denial of food, clothing, or shelter;
 - Cruel, severe, or humiliating actions;
 - Withholding implementation of the child’s case plan;
 - Denial of visits, telephone or mail contacts with family members, unless authorized by a court of competent jurisdiction;
 - Assignment of extremely strenuous exercise or work;
 - Foster parent is cited with, charged with, or arrested due to a violation of law other than a minor traffic offense;
 - Other factors that jeopardize the emotional, mental, physical well-being of the child as defined by Cabinet; and
 - A report of abuse, neglect or dependency that results in a finding that is substantiated or reveals concerns relating to the health, safety and well-being of a child

SERVICE COMPLAINTS/GRIEVANCE PROCESS AND FAIR HEARINGS

Foster parents and foster parent applicants should be aware of the appeal options available to them when they disagree with an action taken by the Department for Community Based Services.

There are two processes:

- SERVICE COMPLAINT PROCESS
- ADMINISTRATIVE FAIR HEARING

(NOTE: These are not appealable through a Service Appeal or Child Abuse and Prevention Treatment Act [CAPTA] Appeal)

These matters include a:

- Decision to deny:
 - Approval of an individual seeking to provide foster or adoptive services in accordance with 922 KAR 1:350 or 922 KAR 1:310; or
 - A caretaker relative approval as a kinship caregiver if the caretaker relative fails to meet the provisions of 922 KAR 1:130, Section 5; We have several foster homes that are caring for relatives.
- Removal of a foster child from a foster home if the foster home parent or another individual residing in the home has been found by the Cabinet to have abused, neglected or exploited a child and the:
 - Foster home parent or other individual waived the right to appeal the substantiated incident;
- Removal of a child from a foster home for the purpose of:
 - Uniting or reuniting the child with a sibling at the next placement;
- Uniting or reuniting the child with a sibling at the next placement;
- Closure of a foster home if the Cabinet has not placed a child in the home within the previous two (2) years;
- Closure of a foster home according to terms of the contract between the Cabinet and the foster home;
- Any situation by which state or federal law requires adjustment of a payment or grant, except when a payment or grant computation is incorrect;
- Decision to not recommend a foster home parent in accordance with 922 KAR 1:350, Section 9(12) for enrollment in specialized training as an emergency, medically complex, specialized medically complex or care plus foster home;
- A complaint of discrimination.

A foster parent may submit a written request to the service region administrator (SRA) or designee within thirty (30) calendar days after the date of the Cabinet/DCBS action or alleged act. The DPP-154 Protection and Permanency Service Appeal form is used to make the written request. The SRA or designee in the region where the foster home is located is required to provide a written response within thirty (30) calendar days of receipt of a request for resolution.

The foster parent may also contact the Cabinet's Office of Ombudsman at (800) 372-2973, if the matter was not previously reviewed by that office.

If you do not wish to speak with the Office of Ombudsman, you may submit your complaint or grievance in writing to a Service Region Administrator or designee no later than 30 days from the date of a Cabinet action to which you object.

You may address the following through an **administrative fair hearing** if the Department for Community Based Services:

- Fails to process reimbursement to a foster home with reasonable promptness;
- Fails to provide information required by KRS 605.090;
- Fails to advise an Adoptive Parent of availability of adoption assistance in accordance with 42 U.S.C. 673 and 922 KAR 1:050;
- Fails to provide an Adoptive Parent, except as otherwise noted by law, with known facts regarding the:
 - Child;
 - Child's background prior to finalization of adoption; and
 - Child's biological family;
- Determines the ineligibility for adoption assistance upon execution of an adoptive placement agreement under 922 KAR 1:050;
- Denies a request for a change in payment level due to a change in an Adoptive Parent or child's circumstances at the time of renewal of an adoption assistance agreement under 922 KAR 1:050;
- Closes a foster home under 922 KAR 1:350, family preparation, except as noted;
- Denies or delays placing a child for adoption with a family outside the jurisdiction of Kentucky.
- A kinship caregiver may request an administrative hearing if the:
 - Cabinet denies supportive services to facilitate the child's placement with the kinship caregiver;
 - Cabinet denies a request for start-up costs to facilitate the child's adjustment to the new environment with the kinship caregiver;
 - Kinship caregiver is dissatisfied with an action or inaction on the part of the Cabinet relating to financial assistance under the kinship care program.
- An individual aggrieved by an action of the Cabinet may request review of the following through an administrative hearing if:
 - The Cabinet denies, reduces, suspends or terminates services or federal funded benefits, payments or financial assistance to which an individual may be entitled under 922 KAR Chapters one (1) through six (6);
 - The Cabinet fails to act with reasonable promptness to a request for a federally funded benefit, payment or financial assistance to which an individual may be entitled under 922 KAR Chapters one (1) through six (6)

An individual found by the Cabinet to have abused or neglected a child may appeal the Cabinet's finding through an administrative hearing in accordance with 922 KAR 1:48. The **SSW or Cabinet/DCBS staff** are required to provide any individual found to have abused or neglected a child a **DPP-155 Request for Appeal of Child Abuse or Neglect Investigative Finding** at the time the notice of substantiated findings is provided to the perpetrator.

The following matters are **not** appealable through a CAPTA administrative hearing:

- A matter which a civil court having competent jurisdiction:
 - Has heard evidence and made a final judicial determination that abuse or neglect of a child did or did not occur; or
 - Is currently engaged in legal proceedings regarding the same issue being appealed;
- A matter in which an appellant has been criminally charged and convicted of an action that is the basis of the Cabinet's finding of abuse or neglect of a child;
- A final administrative decision made by the Cabinet or Cabinet's designee as a result of a previous appeal on the same issue;
- An appeal that has been abandoned by an appellant who failed to demonstrate good cause for failure to go forward;
- Failure to submit a written request for appeal within the required thirty (30) calendar days from the date the notice of the substantiated finding of abuse or neglect is mailed or of the delivery notice if not mailed;
- An investigation that results in an unsubstantiated finding of abuse or neglect of a child.

CHILD PROTECTION SERVICES (CPS) OPEN RECORDS REQUEST AND DISCLOSURE OF INFORMATION

If a situation in your home causes a case to be open for you and your family, you may access the records generated by that case, except for adoption and termination case records, which may only be shared upon receipt of a court order from the court of jurisdiction that granted the adoption and/or termination.

Before you can have access to your case records, staff complies with confidentiality laws so that proper disclosure is made. A request for case records from anyone not expressly permitted by Kentucky Revised Statute (KRS) without legal access will be subject to disclosure only upon order of a court of competent jurisdiction. If you request someone other than yourself to review your case record, that person is required to provide Records Management Section with a signed authorization by you to allow access/disclosure of the case record.

When you request access/disclosure of your case record, DPP and staff at the local or regional office will:

- Provide you with the **DPP-010 Open Records Request**, to facilitate the request;
- For health information, you use the **CHFS-305 Authorization for Disclosure of Protected Health Information** or **CHFS-305A Authorization for Disclosure of Psychotherapy Information**. You direct health information related requests information to:

Cabinet for Health and Family Services
Department for Community Based Services
Records Management Section
275 E. Main St., Section 3E-G
Frankfort, KY 40621

- Provide assistance to you in completing the form(s);
- Advise you that the Records Management Section will respond to their request; and
- Immediately fax the request to the Records Management Section at (502) 564-9554, if a local or regional office receives a written request for records;
- Contact the Records Management Section to confirm receipt of the fax after the request has been faxed.

AIDS/HIV INFORMATION AND TESTING

When a foster parent is contacted for a placement, the social services worker or R&C worker will not disclose a child's HIV status prior to approval of the placement or before the foster parent accepts the placement. This practice may also apply to other serious health conditions that are not considered to be contagious diseases. Only when the foster parent accepts placement is the parent entitled to receive HIV information. The SSW may disclose the child's HIV/AIDS status on an as needed basis.

Children should be screened for HIV/AIDS if it is determined by DCBS that the child or parent may have been exposed to the virus based on specific conditions. The request for HIV/AIDS screening shall be handled by the SSW in a discreet, confidential manner. If there is a positive screening result, the child's SSW and placement foster parent will be notified.

Foster parents should not disclose information about a child's HIV status without consulting with the child's SSW and reviewing SOP. As few people as possible should be notified, depending on the circumstances of the case as HIPAA (Health Insurance Portability and Accountability Act) regulations apply. Respite providers may be told that the child has a serious health condition and instructed to use universal precautions.

It is recommended that children who are known to be HIV positive and their foster parent should receive specialized counseling services and support to help them manage the illness and to make plans for any necessary medical treatment.

AIDS is not spread by casual contact. You can safely care for a child with AIDS. When the HIV/AIDS virus is outside the human body it is weak and cannot be spread through casual contact. Household disinfectants, such as chlorine bleach will kill the virus.

When caring for a child with HIV/AIDS you can hold their hands, hug and kiss them and if crying, dry their tears. A child who has HIV/AIDS can use the same utensils, dishes, glasses, eat at the same table and be served from the same dish as the rest of the family. Wash the dishes as you normally would, using hot water and soap and rinsing with hot water. The child's clothing may be washed with the family wash, unless soaked with blood or other body fluids.

BIRTH CONTROL AND PREGNANCY

The SSW is responsible for ensuring sexual health education, including information on sexually transmitted diseases and birth control is provided to a child in care. The information should be appropriate to the child's individual age and physical and emotional maturity. The SSW should involve the child's physician, medical professional or counselor in sexual health decisions when possible and appropriate. The child should be encouraged to discuss these matters with his/her parents when appropriate.

Should a child/youth become pregnant while in foster care, efforts should be made to ensure prenatal care is provided. The child's SSW should assist the youth in locating the appropriate information and resources needed to explore the youth's options.

The youth should make an informed decision without undue influence and/or coercion by DCBS, the foster parent or biological parents. If the youth elects to give birth and care for the infant, every effort must be made to keep the young adult and infant together.

REPORTING CHILD ABUSE AND NEGLECT

As a foster parent under Kentucky Revised Statute, KRS 620.030 you have a duty to report dependency, neglect or abuse of a child. If you suspect that a child is being abused or neglected, call the Kentucky Child/Adult Abuse Hotline toll-free at

(800) 752-6200. The Child Abuse Hotline operates 24 hours a day, seven days a week.

Non-emergency matters may be reported online at:

<https://prd.chfs.ky.gov/ReportAbuse>

TYPES OF ABUSE/NEGLECT TO REPORT

Physical Abuse, Sexual Maltreatment, Sexual Exploitation, Neglect, Lack of Supervision, Medical Neglect, Educational Neglect, Emotional Maltreatment, Human Trafficking.

KRS 620.030 mandates:

(1) Any person who knows or has reasonable cause to believe that a child is dependent, neglected, or abused shall immediately cause an oral or written report to be made to a local law enforcement agency or the Kentucky State Police; the Cabinet or its designated representative; the Commonwealth Attorney or County Attorney; by telephone or otherwise. Any supervisor who receives from an employee a report of suspected dependency, neglect or abuse shall promptly make a report of abuse or neglect allegedly committed by a person other than a parent, guardian or person exercising custodial control or supervision, the Cabinet shall refer the matter to the Commonwealth Attorney or County Attorney and the local law enforcement agency or the Kentucky State Police.

If you believe a child is being abused, neglected or is dependent, Please call the Child Protection Hot Line:

1-877-KYSAFE1

or

1-877-597-2331

For more area specific phone numbers please go to the Service Regions web page at

<http://chfs.ky.gov/dcbs/serviceregions.htm>

CHILD PLACEMENT CHANGES

The child's SSW makes placement changes only after careful consideration of all available alternatives for support of the current placement (unless the placement is deemed not to be in the best interest of the child's safety, permanency and well being).

When it is determined that movement of the child from a foster home is necessary in order to accomplish timely legal permanence, the SSW follows guidelines found in the Process Overview, in addition to the following procedures.

The SSW sends the foster parent the DPP-154A, Notice of Intended Action, ten (10) days prior to the move. The SSW includes in the notice: CHFS's intention to remove the child from the foster home; the reason for the intended removal; the actual or estimated date when the child will be removed from the foster home; and notice of the foster parent's right to appeal.

If the foster parent requests a hearing within ten calendar days of receiving the written notice, the child is not removed until a decision is rendered after a hearing, unless the SRA or designee determines that continuation in the foster home endangers the safety, permanency or well-being of the child.

When it is determined that movement of the child from a DCBS foster home is necessary because a risk of harm to the child exists, the SSW discusses the situation with the foster parent to determine if the risk of danger to the child can be removed, unless CHFS determines that such discussion would endanger the child's physical, mental, or emotional well-being.

The SSW sends the foster parent the DPP-154A, Notice of Intended Action, ten days prior to the action, if risk of danger cannot be removed or the situation resolved. The SSW includes the following: CHFS's intention to remove the child from the foster home; the reason for the intended removal; the actual or estimated date when the child will be removed from the foster home; and notice of the foster parent's right to appeal the decision. If staff determines that prior notice endangers the safety or well-being of the child, the DPP-154A, Notice of Intended Action is given to the foster parent on the date of action.



ABBREVIATIONS COMMONLY USED BY DCBS STAFF

AA: Adult Adoptee

ADD: Attention Deficit Disorder

ADHD: Attention Deficit-Hyperactivity Disorder

ADT: Assessment and Documentation Tool

ANSA: Annual Needs Strengths Assessment

AOC: Administrative Office of the Courts

APS: Adult Protective Services

ASFA: Adoption and Safe Families Act

BM: Biological Mother

BF: Biological Father

CA/N: Child Abuse and Neglect

CASA: Court Appointed Special Advocates

CBW: Children's Benefits Worker

CFCIP: Chafee Foster Care Independence Program (formerly Independent Living Program)

CFSR: Child and Family Services Review

CI: Central Intake for Investigation

COMPASS: Computer Adaptive Placement Assessment and Support System

CPS: Child Protective Services

CRP: Children's Review Program

CQA: Continuous Quality Assessment (discontinue use on January 21, 2014 see ADT)

CRC: Central Registry Check

DAFM: Division of Administration and Financial Management

DCBS: Department for Community Based Services

DJJ: Deputy Juvenile Justice

DBHIID: Department of Behavioral Health and Individuals with Intellectual Disabilities

DOB: Date of Birth

DOE: Department of Education

D/N/A: Dependency Neglect and Abuse Court Proceedings

DRS: Director of Service Regions

DSS: Department of Social Services

ECO: Emergency Custody Order

EPAS: Educational Planning and Assessment System
EPSDT: Early Periodic Screening, Diagnosis and Treatment
FACTS: Families and Children Together Safely (FPP Program)
F.A.S.Track: Foster Adoptive Support and Training Program (publication produced biannually)
FCS: Family-Centered Services
FAPE: Free and Appropriate Public Education
FP: Foster Parent
FPP: Family Preservation Program
FS: Family Support Division
FSOS: Family Services Office Supervisor
FTM: Family Team Meeting
GAL: Guardian ad Litem (Lawyer to represent the child)
ICAMA: Interstate Compact on Adoption and Medical Assistance
ICPC: Interstate Compact for the Placement of Children
ICWA: Indian Child Welfare Act
IEP: Individualized Educational Plan
IFRS: Intensive Family Reunification Services
IHS/IIS: Intensive In-Home Services (formerly called Family Preservation Services)
ILA: Independent Living Arrangement
ILP: Independent Learning Plan
ILP: Independent Living Program
IOC: Inter-Office Communication
JO: Juvenile Office/Officer
JSO: Juvenile Sex Offender
KCHIP: Kentucky Children's Health Insurance Program
K-PREP: Kentucky Performance Rating for Educational Progress
KDE: Kentucky Department of Education
KECSAC: Kentucky Educational Collaborative for State Agency Children
KFACA: Kentucky Foster Adoptive Care Association
KSBA: Kentucky School Board Association
KYOTE: Kentucky Online Testing Program
LD: Learning Disorder
LFPA: Local Foster Parent Association
LRE: Least Restrictive Environment

MC: Medically Complex
MEPA: Multi-Ethnic Placement Act
NETWORK: The Kentucky Foster and Adoptive Parent Training Support Network
NFPA: National Foster Parent Association
OOHC: Out of Home Care
PCC: Private Child Care
PCP: Private Child Placing
PIP: Program Improvement Plan
PPLA: Planned Permanent Living Arrangement.
PPR: Permanency Planning Review
PS: Protective Services
PS: MAPP Permanency and Safety: Model Approach to Partnerships in Parenting
R&C: Recruitment and Certification
RPMP: Foster Parent Mentor Program
SAFE: Special Advocates For Education
SNAP: Special Needs Adoption Program
SRA: Service Region Administrator
SRAA: Service Region Administrator Associate
SRCA: Service Region Administrator Clinical Associate
SSA: Social Services Aide
SSI: Supplemental Security Income
SSN: Social Security Number
SSS: Social Services Specialist
SSW: Social Services Worker
SSCL: Social Services Clinician
STARS: Specialized Training, Assessment, Resources, Support and Skills
TANF: Temporary Assistance to Needy Families
TPR: Termination of Parental Rights
TRIS: Training Record Information System
TRO: Temporary Removal Hearing
TWIST: The Workers Information SysTem
UKTRC: University of Kentucky Training Resource Center
WIC: Women, Infants and Children

COMMONLY USED DEFINITIONS

Along with the following terms are five designations that come from the law or group of clients the Cabinet serves. They are:

- **APS** - Adult Protective Services
- **CPS** - Child Protective Services
- **HIPAA** - Health Insurance Portability and Accountability Act (HIPAA) of 1996
- **Foster homes**
- **Status** - Persons under 18 who have broken the law - Status Offenders

Abuse (APS)

The infliction of physical pain, mental injury, or injury of an adult.

Abused or Neglected Child (CPS)

A child whose health or welfare is harmed or threatened with harm when his parent, guardian, or other person exercising custodial control or supervision of the child:

- (a) Inflicts or allows to be inflicted upon the child physical or emotional injury as defined in KRS 600.020 by other than accidental means;
- (b) Creates or allows to be created a risk of physical or emotional injury as defined in this section to the child by other than accidental means;
- (c) Engages in a pattern of conduct that renders the parent incapable of caring for the immediate and ongoing needs of the child including, but not limited to, parental incapacity due to alcohol and other drug abuse as defined in KRS 222.005(12);
- (d) Continuously or repeatedly fails or refuses to provide essential parental care and protection for the child, considering the age of the child;
- (e) Commits or allows to be committed an act of sexual abuse, sexual exploitation, or prostitution upon the child;
- (f) Creates or allows to be created a risk that an act of sexual abuse, sexual exploitation, or prostitution will be committed upon the child;
- (g) Abandons or exploits the child; or
- (h) Does not provide the child with adequate care, supervision, food, clothing, shelter, and education or medical care necessary for the child's well-being. A parent or other person exercising custodial control or supervision of the child legitimately practicing the person's religious beliefs shall not be considered a negligent parent solely because of failure to provide specified medical treatment for a child for that reason alone. This exception shall not preclude a court from ordering necessary medical services for a child; or
- (i) Fails to make sufficient progress toward identified goals as set forth in the court approved case plan to allow for the safe return of the child to the parent that results in the child remaining committed to the Cabinet and remaining in foster care for 15 of the most recent 22 months.

Administrative Hearing

"Administrative hearing" or "hearing" means any type of formal adjudicatory proceeding conducted by an agency as required or permitted by statute or regulation to adjudicate the legal rights, duties, privileges or immunities of a named person.

Adolescent household member (Foster homes)

Means a youth who resides in the home of an individual who applies for approval to provide foster and adoptive services, and is age 12 through age 17.

Adoption

The legal process by which a child becomes the child of a person or persons other than biological parents.

Adoption Assistance

Payment of a monthly maintenance to assist in meeting the special needs of a child who was placed by the Cabinet. Assistance may also include payment of nonrecurring adoption expenses and reimbursement of extraordinary medical expenses.

Adoption Assistance Agreement

An agreement setting forth the scope and limits of the adoption assistance signed by the adoptive parents and the secretary of the Cabinet or designee.

Adoption Disruption

The discontinuance of a child's placement after signing of adoption placement agreement with a prospective adoptive family and prior to the finalization/legalization of the adoption.

Adoption Dissolution

The discontinuance of an adoption at any point in time after the adoption has been finalized/legalized.

Adoption Judgment

The decree of the Circuit/Family Court granting and legalizing/finalizing the adoption (KRS 199.520).

Adoption Petition

The document filed with Circuit/Family Court by the person or persons initiating the process to adopt a particular child (KRS 199.470, 199.480, and 199.490).

The Adoption and Safe Families Act or ASFA

Establishes goals of safety, permanency, child well-being and outcomes in the areas of safety and stability while in placement. Permanency is to be achieved in a limited amount of time while engaging appropriate physical, mental and educational services for children served. In order to meet ASFA goals and achieve its outcomes, adoption services must:

- Consider the needs of birth parents;
- Focus on the child and his/her need for safety, permanency and well-being;
- Recognize the critical role of foster parents; and,
- Prepare, select and support adoptive parents.

Adult (APS)

A person eighteen (18) years of age or older who has a mental or physical dysfunction, is not able to manage their own money or resources, or carry out the activities of living, or is not able to protect themselves from a neglectful or a hazardous or abusive situation

if they do not have the assistance from others and who may be in need of some type of protective services;

A person without regard to age who is the victim of abuse and neglect that is inflicted by the spouse; or

A person in an ongoing, cohabiting and intimate relationship who is eighteen (18) years of age or older and the victim of alleged abuse by a partner. (Ireland v Davis, Ky. App., 957 S. W. 2nd 310 (1997)).

Adult household member (Foster homes)

Means an adult who resides in the home of an individual who applies for approval to provide foster or adoptive services, and is age 18 or older.

Agency Adoptions

Those planned and handled by any licensed child-placing adoption agency, including DCBS.

Aggravated Circumstances

The existence of one (1) or more of the following conditions:

1. The parent has not attempted or has not had contact with the child for a period of not less than ninety (90) days;
2. The parent is incarcerated and will be unavailable to care for the child for a period of at least one year from the date of the child's entry into foster care and there is no appropriate relative placement available during this period of time;
 - (a) The parent has sexually abused the child and has refused available treatment;
 - (b) The parent has been found by the Cabinet to have engaged in abuse of the child that required removal from the parent's home two or more times in the past two years; or
 - (c) The parent has caused the child serious physical injury.

Annual Re-evaluation Report (Foster Homes)

Is a periodic joint evaluation process used by DCBS and Foster home parents to assess the changes in the family, review the family's ability to meet the needs of children, and determine continuing compliance.

Applicant

Means an individual or family, subject to approval by the Cabinet as a foster home.

Beyond Control

A child who has repeatedly failed to follow the reasonable directives of his or her parents, legal guardian, or person exercising custodial control or supervision other than a state agency, which behavior results in danger to the child or others, and which behavior does not constitute behavior that would warrant the filing of a petition under KRS Chapter 645.

Cabinet

Means the Cabinet for Health and Family Services

CAPTA

Child Abuse Prevention Treatment Act

Care Plus Foster home

Provides services to a child who is a level 3 or above and :

- Is due to be released from a treatment facility;
- Is at risk of being placed in a more restrictive setting;
- Is at risk of institutionalization;
- Has experienced numerous placement failures;
- Has an emotional or behavioral problem; or
- Displays aggressive, destructive, or disruptive behaviors.

Care plus foster parents **coordinate** treatment services with community providers as developed with the SSW, but **do NOT provide** treatment services.

Caretaker

Def 1: CPS- A person who is responsible for the supervision and well-being of a child.

Def 2: APS- An individual or institution who has the responsibility for the care of the adult as a result of family relationship, or who has assumed the responsibility for the care of the adult person voluntarily, or by contract, or agreement.

Caretaker neglect (APS)

The deprivation by a caretaker of services, which are needed to maintain health and welfare. The caretaker arrangement can be formal (e.g., contractual, institution, etc.) or informal (e.g., voluntary agreement with family member, friend, etc.). The caretaker neglect can be either “passive” (unintentional) or “active” (intentional) in nature related to the provision of services (e.g., food, clothing, shelter, social contact, personal needs, medical care, etc.) and may include, but is not limited to:

Lack of adequate food or health related services due to the caretaker’s inadequate skills or knowledge;

- Abandonment or lack of supervision;
- Unmet personal or medical needs, including bedsores, malnourishment, dehydration, inappropriate clothing, poor hygiene, incorrect use of medicines, lack of food or inadequate food;
- Withholding or deprivation of food/water or health services;
- Overmedicating or under medicating;
- Forcing isolation;
- Not obtaining needed mental health or medical services/treatment; or
- Permitting unnecessary pain.

Case Permanency Plan

A document identifying decisions made by the Cabinet, for both the biological family and the child, concerning action which needs to be taken to ensure that the child in foster care expeditiously obtains a permanent home.

Case Progress Report

A written record of goals that have been achieved in the case of a child.

Case record

A Cabinet file of specific documents and a running record of activities pertaining to the child.

Certified Juvenile Facility Staff

Individuals who meet the qualifications of, and who have completed a course of education and training in juvenile detention developed and approved by, the Department of Juvenile Justice after consultation with other appropriate state agencies.

Child

Any person who has not reached his eighteenth birthday, unless otherwise provided.

Child Protective Services (CPS)

Preventive and corrective services directed toward:

- Safeguarding the rights and welfare of an abused, neglected or dependent child;
- Assuring for each child a safe and nurturing home;
- Improving the abilities of parents to carry out parental responsibilities;
- Strengthening family life; and assisting a parent or other person responsible for the care of a child in recognizing and remedying conditions detrimental to the welfare of the child.

Child-Caring Facility

Any facility or group home other than a state facility, Department of Juvenile Justice contract facility or group home, or one certified by an appropriate agency as operated primarily for educational or medical purposes, providing residential care on a 24-hour basis to children not related by blood, adoption, or marriage to the person maintaining the facility.

Children's Advocacy Center

An agency that advocates on behalf of children alleged to have been abused, that assists in the coordination of the investigation of child abuse by providing a location for forensic interviews and medical examinations, and by promoting the coordination of services for children alleged to have been abused, and that provides, directly or by formalized agreements, services that include, but are not limited to, forensic interviews, medical examinations, mental health and related support services, court advocacy, consultation, training and staffing of multidisciplinary teams.

Circuit Court Commitment

An Order of Judgment Terminating Parental Rights (TPR) granting permanent custody of a child to the Cabinet or another child-placing adoption agency until permanency or majority is achieved for a child. (KRS Chapter 625.043 and 625.100).

Clinical Treatment Facility

A facility with more than eight beds designated by the Department of Juvenile Justice or the Cabinet for the treatment of mentally ill children. The treatment program of such facilities shall be supervised by a qualified mental health professional.

Conflict of Interest

A situation in which a public official's (employee) decisions are influenced by the official's (employee) personal interests.

Commitment

An order of the court which places a child under the custodial control or supervision of the Cabinet for Health and Family Services, Department of Juvenile Justice, or another facility or agency until the child attains the age of eighteen (18) unless the commitment is discharged under KRS Chapter 605 or the committing court terminates or extends the order.

Community-Based Facility

Any non-secure, homelike facility licensed, operated or permitted to operate by the Department of Juvenile Justice or the Cabinet, which is located within a reasonable proximity of the child's family and home community, which affords the child the opportunity, if a Kentucky resident, to continue family and community contact.

Complaint (CPS/Status)

A verified statement setting forth allegations in regard to the child which contain sufficient facts for the formulation of a subsequent petition.

Complaint (HIPAA)

Refers to any concern communicated by a person questioning any act or failure to act relating to an individual's rights to access to his/her health information, to maintain the privacy of his/her health information, to request restrictions on uses or disclosures of his/her PHI, to request confidential communications regarding his/her PHI, to request amendment of his/her PHI, or to receive an accounting of disclosures of his/her PHI.

Concurrent Planning

The Cabinet simultaneously plans for reunification of a child with the birth family, relative placement or permanent removal of the child if the prognosis for reunification is poor. Adoption is considered only after all other permanency options have been exhausted.

Consent to Adoption

Is a written, signed and sworn statement granting permission to the child's adoption by the authorized representative of the agency having permanent legal custody of the child, or other persons having permanent legal custody. (KRS 199.011(14) and KRS 199.500).

Consent to Voluntary Commitment

The Cabinet may accept custody of a child who is voluntarily committed by the child's parent, guardian, or other person having legal custody.

Developmental Disability (APS)

A severe, chronic disability of a person which:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments, including pervasive developmental disorder;

2. Is manifested before the person attains age 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity:
 - (a) Self-care;
 - (b) Receptive and expressive language;
 - (c) Learning;
 - (d) Mobility;
 - (e) Self-direction;
 - (f) Capacity for independent living; and
 - (g) Economic self-sufficiency; and
5. Reflects the person's need for a combination and sequence of special interdisciplinary or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

Disabled (APS)

Means a legal, not a medical disability, and is measured by functional incapacities. It refers to any person fourteen (14) years of age or older who is: (a) Unable to make informed decisions with respect to his personal affairs to such an extent that he lacks the capacity to provide for his physical health and safety, including but not limited to health care, food, shelter, clothing, or personal hygiene; or (b) Unable to make informed decisions with respect to his financial resources to such an extent that he lacks the capacity to manage his property effectively by those actions necessary to obtain, administer, and dispose of both real and personal property. Such inability shall be evidenced by acts or occurrences within six (6) months prior to the filing of the petition for guardianship or conservatorship and shall not be evidenced solely by isolated instances of negligence, improvidence, or other behavior.

Disclosure (HIPAA)

Refers to the release, transfer, and provision of access to or divulging in any other manner of information outside the entity holding the information.

District Court Commitment

Is an order of District Court granting temporary custody of a child to the Cabinet or in Kinship Care cases to the relative. The District Court may also grant permanent custody to relatives in Kinship Care cases.

Diversion Agreement (CPS/Status)

An agreement entered into between a court-designated worker and a child charged with the commission of offenses set forth in KRS Chapters 630 and 635, the purpose of which is to serve the best interest of the child and to provide Redress for those offenses without court action and without the creation of a formal court record.

Emergency Shelter

Is a group home, private residence, foster home, or similar homelike Facility, which provides temporary or emergency care of children and adequate staff and services consistent with the needs of each child.

Emotional injury

An injury to the mental or psychological capacity or emotional stability of a child as evidenced by a substantial and observable impairment in the child's ability to function within a normal range of performance and behavior with due regard to his age, development, culture, and environment as testified to by a qualified mental health professional.

Emotional Risk

As foster parents for children in care we develop an expected outcome for each child in our care. Because the actual outcome for a child in care is not in our direct control, we run the risk of experiencing negative feelings if the outcome is not what we expect. The further away from our expectation the actual outcome is, the more conflict we feel.

Entitlement

Entitlement is a feeling, developed over time, that you know what is best and have more rights in an out-of-home case than you really do. This feeling, that what you want in a case should happen, leads to higher emotional risk because you may discount the efforts and opinions of others to the point where you think everyone else is wrong and has "turned against you". This is very dangerous for you emotionally and can hinder your ability to be objective and therefore to be a foster parent.

Essential Needs

As described by Maslow's hierarchy of needs, would be safety planning, food supplies, shelter requirements, emergency supplies, etc.

Family-in-need-of-services assessment or FINSA

A process of collecting information and evaluating risk factors to determine if a family is in need of child protective services.

Food-related expenses (Foster homes)

Includes nonalcoholic beverages and food purchases at the grocery, convenient and specialty stores, restaurants and household expenditures on school meals.

Foster Care

The provision of temporary 24-hour care for a child for a planned period of time when the child is:(a) Removed from his parents or person exercising custodial control or supervision and subsequently placed in the custody of the Cabinet; and (b) Placed in a foster home or private child-caring facility or child-placing agency but remains under the supervision of the cabinet.

Foster Family Home (CPS)

Means a private home in which children are placed for foster family care under supervision of the Cabinet or a licensed child-placing agency, etc.

Foster Home Contract (Foster homes)

Is the written contract, OOH 111, and supplement, OOH 111A, which details mutual expectations of DCBS and the foster home for the 24-hour care of a child.

Foster home's "own children"

Refers to the children residing in the family's home such as biological and adopted children and those of extended relatives and friends who are living in the home.

Foster or Adoptive Family Foster home Review

Is the assessment process used by DCBS when factors are identified which may put the family under stress and may affect a child's placement.

Found and Substantiated (CPS)

An investigatory finding of physical abuse, sexual abuse, neglect or dependency not originally reported by the referral source but was found and substantiated during the investigation.

General Adult Services (APS)

Means a voluntary preventive service aimed at assisting: (a) An adult to attain and function at his highest level of self-sufficiency and autonomy; and (b) In maintaining the adult in the community.

Group Preparation and Selection or GPS (Foster homes)

Is the joint assessment process used by DCBS and the applicant for the purpose of determining whether the family can serve children whom DCBS has made available for placement, and how they can best meet these children's needs.

Habitual Runaway

Any child who has been found by the court to have been absent from his place of lawful residence without the permission of his custodian for at least three (3) days during a one (1) year period.

Habitual truant

Any child who has been found by the court to have been reported as a truant as defined in KRS 159.150 three (3) or more times during a one (1) year period.

Health Insurance Portability and Accountability Act (HIPAA) of 1996

HIPAA A Federal Act to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud and abuse in health insurance and health care delivery. HIPAA provides the first comprehensive federal protection for the privacy of health care information.

Health professional

Means a person actively licensed in Kentucky as a:

- Physician;
- Physician's assistant;
- Advanced registered nurse practitioner; or
- Nurse clinician under the supervision of a physician.

Hospital

Except for purposes of KRS Chapter 645, a licensed private or public facility, health care facility, or part thereof, which is approved by the Cabinet to treat children.

Housing expenses

Includes the costs of shelter, utilities, household furnishings and equipment.

Human Trafficking

Human trafficking, also known as trafficking in persons (TIP), is a modern-day form of slavery.

Sex trafficking is the recruitment, harboring, transportation, provision, or obtaining of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age (22 USC § 7102; 8 CFR § 214.11(a)).

Labor trafficking 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 purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery (22 USC § 7102).

Imminent risk

Means immediate threat of injury or harm to a child when no interventions have occurred to protect the child. This may include requesting assistance from law enforcement for immediate removal of a child or petitioning the court for an emergency custody order. Additionally, the central intake worker consults the FSOS and/or regional staff and takes other actions to determine that a child is not in danger and that removal is not needed for the child's protection within 24 hours of the initial report.

The worker may use the following in determining imminent danger:

- Children with serious injuries from physical abuse;
- Children suffering from acute untreated medical condition(s) that demand urgent attention whose parent(s) is refusing to obtain treatment or cannot be located;
- Self-referral from a parent or guardian who states they are currently unable to cope or feel they may harm their children;
- Children who express fear of their current circumstances, serious sexual or physical abuse or if neglect appears imminent;
- Children presently receiving bizarre forms of punishment, e.g. locked in closets or tied to a chair or bed;
- Children at risk of immediate harm from parents who are in a psychotic episode or are behaving in a bizarre manner;
- Abandoned children who are currently without supervision of a responsible adult; (Abandonment is defined as leaving without any intent to return).
- Children under 8 years of age who are currently without supervision by a responsible person (The investigation shall determine the child's level of maturity, development and ability to function safely alone and whether the family has an established plan of action in case of emergency)
- Situations involving weapons; or,
- Other situations which in the judgment of the FSOS and SSW constitute immediate risk to a child.

In-Home Visit

Any visit that takes place at an individual's current residence, including but not limited to homeless shelters, domestic violence shelters, prisons, etc. The visit may only

be accepted as meeting SOP requirements if the visit accomplishes case-specific intervention tasks, as well as:

- Providing the family with information about their child,
- Conducts initial and ongoing family assessments;
- Reviews the family's progress toward accomplishment of their case planning tasks, goals, and those of other service providers;
- Evaluates the family's visitation with the child;
- Preparing for a Case Planning Conference, Periodic Review, or Court Hearing;
- Obtaining additional assessment and/or planning information;
- (When appropriate) preparing an Aftercare Plan.

Independent Adoptions

Are those in which the placement of the child is arranged and made by a person or persons other than the Cabinet or a licensed child-placing adoption agency. Independent adoptions consist of two categories: relative and non-relative placements. (KRS 199.473 and 199.590).

Independent Living

Those activities necessary to assist a committed child to establish independent living arrangements.

Daily Living Skills include knowledge of such items as:

- Menu planning, shopping, cooking and serving;
- Basic laundry and house cleaning;
- Basic health care and personal hygiene;
- Accessing local community resources;
- Developing appropriate leisure time activities;
- Basic money management and consumerism;
- Basic employment; and
- Basic housing.

Soft skills include knowledge of such items as:

- Anger management;
- Decision-making;
- Problem-solving;
- Time management;
- Positive attitudes and communication;
- Positive self-concept and self-esteem;
- Development of good interpersonal relationships;
- Self-control; and
- Social etiquette.

Independent living services

Means services provided to youth to assist them in the transition from the dependency of childhood to living independently.

Indian Child Welfare Act or ICWA

The Indian Child Welfare Act (ICWA) of 1978 is a federal law that governs the removal and out of home placement of American Indian children. The law was enacted after recognition by the federal government that American Indian children were being removed from their homes and communities at a much higher rate than non-Native children. Under ICWA standards were established for the placement of Indian children in foster and adoptive homes and allowed tribes and Indian families to be involved in child welfare cases.

Initiate (CPS)

An attempt to make a face-to-face contact with a reported victim/s within time frames. When a physical attempt to locate the alleged victim is not achieved within the required time frames, the record must identify that “legitimate” attempts were made to locate the alleged victim, i.e. negative home visits, collateral contacts such as family support for verification of address, utility company, etc. or visits to a school, if appropriate, or visits to foster homes. When was there face-to-face contact? (If all FSW efforts to locate the victim/s failed, FSOS must be contacted within 24 hours for consultation, including weekends).

Intentionally (CPS)

With respect to a result or to conduct described by a statute which defines an offense, that the actor’s conscious objective is to cause that result or to engage in that conduct.

Interdisciplinary Evaluation Report (APS)

Means a report of an evaluation of a respondent performed pursuant to the provisions of KRS 387.540 to determine whether he is partially disabled or disabled as defined herein. Interested person or entity means an adult relative or friend of the respondent or ward, an official or representative of a public or private agency, corporation, or association concerned with that person’s welfare or any other person found suitable by the court.

Intermittent Holding Facility (CPS/Status)

A physically secure setting, which is entirely separated from sight and sound from all other portions of a jail containing adult prisoners, in which a child accused of a public offense may be detained for a period not to exceed 24 hours, exclusive of weekends and holidays prior to a detention hearing as provided for in KRS 610.265, and in which children are supervised and observed on a regular basis by certified juvenile facility staff.

Interstate Compact on Adoption and Medical Assistance or ICAMA

The Compact which has the force of law within and among the member states. It provides for uniformity and consistency of policy and procedures when a family in another state adopts a child with special needs, or the adoptive family moves to another state.

Investigation (APS)

1. A process:

- (h) Of collecting information and evaluating risk factors to determine if a child has been abused or neglected, or is dependent;
 - (i) Based upon the initial determination that moderate to high risk factors exist.
2. Includes, but is not limited to, a personal interview with the individual reported to be abused, neglected or exploited. When abuse or neglect is allegedly the cause of death, a coroner's or doctor's report shall be examined as part of the investigation.

Juvenile holding facility

A physically secure facility, approved by the Department of Juvenile Justice, which is an entirely separate portion or wing of a building containing an adult jail, which provides total sight and sound separation between juvenile and adult facility spatial areas and which is staffed by sufficient certified juvenile facility staff to provide 24 hours per day supervision.

Least Restrictive Alternative

Except for purposes of KRS Chapter 645, that the program developed on the child's behalf is no more harsh, hazardous or intrusive than necessary; or involves no restrictions on physical movements nor requirements for residential care except as reasonably necessary for the protection of the child from physical injury; or protection of the community, and is conducted at the suitable available facility closest to the child's place of residence.

Licensed Practical Nurse

As defined by KRS 314.011(9) means one who is licensed to perform of acts requiring knowledge and skill such as are taught or acquired in approved schools for practical Nursing in:

- The observing and caring for the ill, injured, or infirm under the direction of a registered nurse, a licensed physician or dentist;
- The giving of counsel and applying procedures to safeguard life and health, as defined and authorized by the board;
- The administration of medication or treatment as authorized by a physician, physician assistant, dentist, or advanced registered nurse practitioner and as further authorized or limited by the board which is consistent with the National Federation of Licensed Practical Nurses or with Standards of Practice established by nationally accepted organizations of licensed practical nurses;
- Teaching, supervising, and delegating except as limited by the board; and
- The performance of other nursing acts which are authorized or limited by the board and which are consistent with the National Federation of Practical Nurses' Standards of Practice or with Standards of Practice established by nationally accepted organizations of licensed practical nurses.

Lifebook

Is a therapeutic process, which helps the child to discover his/her history and identity in simple, age appropriate terms to better enable the child to accept his/her permanency outcome throughout the child's life. The lifebook is usually developed in the form of a scrapbook, with pictures, drawings, and children's narratives of their experience and their feelings about these experiences. Although the use of lifebooks originated within adoption, they are required for all children in out-of-home care.

Limited Conservator

An individual, agency, or corporation appointed by the court to assist in managing the financial resources of a partially disabled person and whose powers and duties have been specifically enumerated by court order.

License Holder

Individual, partnership, corporation or other entity authorized to operate a child-caring facility or child-placing agency, including a board of directors and authorized person for decision making.

Limited Guardian

A guardian who possesses fewer than all of the legal powers and duties of a full guardian, and whose powers and duties have been specifically enumerated by court order.

Medically Complex

Means a child who has a medical condition that is:

Documented by a physician that may become unstable and change abruptly resulting in a life-threatening situation;

1. Chronic and progressive illness or medical condition;
2. A need for special service or ongoing medical support; or
3. A health condition stable enough to be in a home setting only with monitoring by an attending:
 - (a) Health Professional;
 - (b) Registered nurse as defined by KRS 314.011(5); or
 - (c) Licensed practical nurse as defined by KRS 314.011(9).

May only be determined by the Medical Support Section.

Multidisciplinary Team (CPS)

Local teams operating under protocols governing roles, responsibilities, and procedures developed by the Kentucky Multidisciplinary Commission on Child Sexual Abuse pursuant to KRS 431.600.

Multi-Ethnic Placement Act and Inter-Ethnic Placement Act or MEPA/IEPA (CPS)

Federal requirements established to prohibit discrimination, whether directed at children in need of appropriate, safe homes, at prospective parents or at previously "underutilized" communities who could be resources for placing children. The three basic mandates include:

1. Prohibition from delaying or denying a child's foster care or adoptive placement on the basis of the child's or the prospective parent's race, color, or national origin;
2. Prohibition from denying to any individual the opportunity to become a foster or Adoptive Parent on the basis of the prospective parent's or the child's race, color or national origin; and,
3. Diligent recruitment of foster and adoptive parents who reflect the racial and ethnic diversity of the children in the state who need foster and adoptive homes.

Multiple or Dual Relationships

Intimate, social, or other nonprofessional contacts/relationships with clients, family members, foster parents, colleagues and supervisors that could have an impact on their professional objective judgment and performance. Dual or multiple relationships can occur simultaneously or consecutively (friendships, dating, etc.).

Near fatality (CPS)

An injury that, as certified by a physician, places a child in serious or critical condition.

Needs of the child

Necessary food, clothing, health, shelter and education.

Newborn Infant

Defined by KRS 211.951, KRS 216B.190, KRS 405.075, and KRS 620.350 as an infant who is medically determined to be fewer than 72 hours old.

Non-accidental (CPS)

The perpetrator meant to take the action that caused the injury. They do not necessarily need to have intent to cause the injury, such as a bruise, broken bone or abrasion, etc. For instance, if a perpetrator hit a child with a piece of board but did not intend for the child to have a gash on his head as a result, that would not be an accident. However, if turning around to place a board on a table the person inadvertently hits a child (not realizing that the child was standing there) and causes the gash this would be accidental.

Non-secure Facility (CPS/Status)

A facility which provides its residents access to the surrounding community and which does not rely primarily on the use of physically restricting construction and hardware to restrict freedom.

Non-secure setting (CPS/Status)

A non-secure facility or a residential home, including a child's own home, where a child may be temporarily placed pending further court action. Children before the court in a county that is served by a state operated secure detention facility, who are in the detention custody of the Department of Juvenile Justice, and who are placed in a non-secure alternative by the Department of Juvenile Justice, shall be supervised by the Department of Juvenile Justice.

Parent

The biological or adoptive mother or father of a child.

Partially disabled (APS)

Refers to an individual who lacks the capacity to manage some of his personal affairs and/or financial resources as provided in subsection (8) of this section, but who cannot be found to be fully disabled as provided therein.

Permanence (CPS)

A relationship between a child and an adult which is intended to last a lifetime, providing commitment and continuity in the child's relationships and a sense of belonging.

Person exercising custodial control or supervision (CPS/Status)

A person or agency that has assumed the role and responsibility of a parent or guardian for the child, but that does not necessarily have legal custody of the child.

Personal Representative (HIPAA)

A person who has authority under applicable law to make decisions related to health care and other needs on behalf of an adult or an emancipated minor, or the parent, guardian, or other person acting in loco parents who is authorized under law to make health care decisions on behalf of an unemancipated minor, except where the minor is authorized by law to consent, on his/her own or via court approval, to a health care service, or where the parent, guardian or person acting in loco parents has assented to an agreement of confidentiality between the provider and the minor.

Petition

A verified statement, setting forth allegations in regard to the child, which initiates formal court involvement in the child's case.

Physical Abuse (APS)

The infliction of physical pain or injury caused by the offender to the person's body. These are acts, which cause or are intended to cause physical harm and may include, but are not limited to:

- Physical assault, including pushing, kicking, hitting, slapping, punching, strangling, pinching, burning, hair pulling, shoving, stabbing, shooting, beating, battering during pregnancy, striking with an object and/or complaints of pain as a result of the assault
- Physical restraint against one's will;
- Rough handling, including forced feeding, roughness when transferring individual from bed to chair or during bathing, etc; or,
- Inappropriate use of physical or chemical restraints.

Physical injury (CPS)

Substantial physical pain or any impairment of physical condition.

Physically secure facility (CPS/Status)

A facility that relies primarily on the use of construction and hardware such as locks, bars, and fences to restrict freedom.

Planned Permanent Living Arrangement

This is a status for some of our kids who are older and we no longer recruit for because they are working on Independent Living.

Placement for Adoption

The planned date the child and all of his/her belongings move into the adoptive family's residence and the Adoptive Placement Agreement DCBS-195 is signed. Placement shall be based upon the needs of the individual children available for adoption and the ability of the adoptive applicants to meet these needs.

Postlegalization Services

Provided to the adopted person, the adoptive parents and/or birth parents, by the agency providing adoption services or another community resource, after an adoption has been legalized/finalized in Circuit/Family Court.

Postplacement Adoption Services

Provided by the agency completing the adoptive placement, either directly or through referral, to the adoptive parents, adopted child, or the birth parents after a child has been placed for adoption but before the adoption is legalized.

Preplacement Services

Provided to the child, the adoptive parents and/or birth parents by the agency providing adoption services or another community resource prior to the legalization/finalization of the adoption.

Preponderance of Evidence

Means that, in order to support a finding that a particular person has committed child abuse or neglect, the evidence shall be sufficient to allow a reasonable person to conclude that it is more likely than not that:

- (a) The child in question was abused or neglected, or is dependent; and
- (b) The alleged perpetrator committed an act, or fail to act, as established by KRS 600.020(1).

Preventive Services

Those services which are designed to help maintain and strengthen the family unit by preventing or eliminating the need for removal of children from the family.

Professional Experience

Means a paid or volunteer employment in a setting where there is supervision and periodic evaluation.

Protected Health Information or PHI (HIPAA)

Individually identifiable health information related to past, present or future physical or mental health or condition of an individual, provision of health care to an individual or the past, present or future payment for health care provided to an individual.

Protective Services (APS)

Means agency services undertaken with or on behalf of an adult in need of protective services who is being abused, neglected, or exploited. These services may include, but are not limited to conducting investigations of complaints of possible abuse, neglect, or exploitation to ascertain whether or not the situation and condition of the adult in need of protective services warrants further action; social services aimed at preventing and remedying abuse, neglect, and exploitation; and services directed toward seeking legal determination of whether or not the adult in need of protective services has been abused, neglected, or exploited and to ensure that he obtains suitable care in or out of his home.

Public Agency Adoptions

Adoptions arranged by the Cabinet

Public offense action

An action, excluding contempt, brought in the interest of a child who is accused of committing an offense under KRS Chapter 527 or a public offense which, if committed by an adult, would be a crime, whether the same is a felony, misdemeanor, or violation, other than an action alleging that a child sixteen (16) years of age or older has committed a motor vehicle offense.

Qualified Mental Health Professional or QMHP

- A physician licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties;
- A psychiatrist licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the practice of official duties, and who is certified or eligible to apply for certification by the American Board of Psychiatry and Neurology, Inc.;
- A psychologist with the health service provider designation, a psychological practitioner, a certified psychologist, or a psychological associate licensed under the Provisions of KRS Chapter 319;
- A licensed registered nurse with a master's degree in psychiatric nursing from an accredited institution and two years of clinical experience with mentally ill persons, or a licensed registered nurse with a bachelor's degree in nursing from an accredited institution who is certified as a psychiatric and mental health nurse by the American Nurses Association and who has three years of inpatient or outpatient clinical experience in psychiatric nursing and who is currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a regional comprehensive care center;
- A licensed clinical social worker licensed under the provisions of KRS 335.100, or a certified social worker licensed under the provisions of KRS 335.080 with three years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a regional comprehensive care center;
- A marriage and family therapist licensed under the provisions of KRS 335.300 to 335.399 with three years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth, a psychiatric unit of a general hospital, or a regional comprehensive care center; or
- A professional counselor credentialed under the provisions of KRS 335.500 to 335.599 with three years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, or a regional comprehensive care center.

Reasonable Efforts

The exercise of ordinary diligence and care by the department to utilize all preventive and reunification services available to the community in accordance with the state plan for Public Law 96-272 which are necessary to enable the child to safely live at home.

Registered Nurse

As defined by KRS 314.011(5) and (6), means: one who is licensed to perform acts requiring substantial specialized knowledge, judgment and nursing skill based upon the principles of psychological, biological, physical and social sciences in the application of the nursing process in:

1. The care, counsel, and health teaching of the ill, injured, or infirm;
2. The maintenance of health or prevention of illness of others;
3. The administration of medication and treatment as prescribed by a physician, physician assistant, dentist, or advanced registered nurse practitioner and as further authorized or limited by the board, and which are consistent either with American Nurses' Association Standards of Practice or with Standards of Practice established by nationally accepted organizations of registered nurses. Components of medication administration include but are not limited to:
 - (a) Preparing and giving medications in the prescribed dosage, route and frequency, including dispensing medications only as defined in subsection of KRS 314.011(17)(b);
 - (b) Observing, recording, and reporting desired effects, untoward reactions and side effects of drug therapy;
 - (c) Intervening when emergency care is required as a result of drug therapy;
 - (d) Recognizing accepted prescribing limits and reporting deviations to the prescribing individual;
 - (e) Recognizing drug incompatibilities and reporting interactions or potential interactions to the prescribing individual; and
 - (f) Instructing an individual regarding medications;
4. The supervision, teaching of, and delegation to other personnel in the performance of activities relating to nursing care; and
5. The performance of other nursing acts which are authorized or limited by the board, and which are consistent either with American Nurses' Association Standards of Practice or with Standards of Practice established by nationally accepted organizations of registered nurses.

Residential Treatment Facility

A facility or group home with more than eight beds designated by the Department of Juvenile Justice or the Cabinet for the treatment of children.

Foster home

Means a home in which a parent has been certified to provide: foster care services for a child placed in out-of-home care by the Cabinet; adopt a child whose parental rights have been terminated and is under the custodial control of the Cabinet; provide respite service for a family approved to care for a child under the custodial control of the Cabinet; or provide any combination of the services outlined above.

Respite Care

Means temporary care provided by another individual or family to:

- Provide relief to the foster home parents;
- Allow for an adjustment period for the child in OOHC.

Retain in Custody

After a child has been taken into custody, the continued holding of the child by a peace officer for a period of time not to exceed 12 hours when authorized by the court or the court-designated worker for the purpose of making preliminary inquiries.

Reunification Services

Remedial and preventive services, which are designed to strengthen the family unit, to secure reunification of the family and child where appropriate, as quickly as practicable and to prevent the future removal of the child.

Service Complaint

A matter not subject to review through an administrative hearing or service appeal.

School Expenses

Includes school supplies and school fees. Specific items needed in a classroom to enable a child to benefit from a public education are the responsibility of the school (e.g., large print textbooks, teacher's aides, special transportation, etc.).

School Personnel

Those certified persons under the supervision of the local public or private education agency.

Secretary

Means the secretary of the Cabinet for Health and Family Services.

Secure Juvenile Detention Facility

Any physically secure facility used for the secure detention of children other than any facility in which adult prisoners are confined.

Self-neglect (APS)

A situation in which the adult is unable to perform or obtain services, which are necessary to maintain health or welfare. Self-neglect includes, but is not limited to:

- Failure by the adult to address or make arrangements for his/her individual care needs;
- Unmet personal or medical needs, including bedsores, malnourishment, dehydration, inappropriate clothing, poor hygiene, using medicines incorrectly, lack of food or inadequate food;
- Refusing or being unable to access medical or mental health care/treatment;
- Living in an unsafe environment, such as fire/safety hazard, roach/rat/insect infested dwelling or condemned building;
- Living alone and in life-threatening conditions;
- Being unable to manage one's own resources; or,
- A new onset of confusion and/or disorientation.

Serious physical injury (CPS)

Physical injury which creates a substantial risk of death or which causes serious and prolonged disfigurement, prolonged impairment of health or prolonged loss or impairment of the function of any bodily member or organ.

Sexual abuse (APS)

These are acts, which cause or are intended to cause physical harm and may include, but are not limited to:

- Forced sexual relations, including rape, forced sex with others, animals or foreign objects; and,
- Unwanted fondling or touching.

Sexual abuse (CPS)

Includes, but is not necessarily limited to, any contacts or interactions in which the parent, guardian, or other person having custodial control or supervision of the child or responsibility for his welfare, uses or allows, permits or encourages the use of the child for the purposes of the sexual stimulation of the perpetrator or another person.

Sexual exploitation (CPS)

Includes, but is not limited to, a situation in which a parent, guardian or other person having custodial control or supervision of a child or responsible for his welfare, allows, permits, or encourages the child to engage in an act which constitutes prostitution under Kentucky law; or a parent, guardian or other person having custodial control or supervision of a child or responsible for his welfare, allows, permits, or encourages the child to engage in an act of obscene or pornographic photographing, filming or depicting of a child as provided for under Kentucky law.

Social services worker

Any employee of the Cabinet or any private agency designated as such by the secretary of the Cabinet or a social worker employed by a county or city who has been approved by the Cabinet to provide, under its supervision, services to families and children.

Special Needs Adoption Program or SNAP

Is a specific team utilized by the Cabinet to provide consultation to staff and families and to recruit prospective families for Kentucky's waiting children.

Specialized Medically Complex Child

means a child determined by the Cabinet to have a medical condition, documented by a physician, that is severe enough to require placement with a foster home parent who is a:

1. Health professional;
2. Registered nurse as defined in KRS 314.011(5);or
3. Licensed practical nurse as defined in KRS 314.011(9).

Spouse/partner Abuse (APS)

Relates to the infliction of physical pain, injury or mental injury by an individual's spouse or cohabiting partner. Spouse or partner abuse may take many forms and varies with respect to the frequency and severity of the violence.

Spouse/partner Neglect (APS)

The deprivation of services needed for health and welfare and may include, but is not limited to:

- Actively prohibiting the spouse or partner from obtaining needed medical care; and

- Controlling the environment to the extent that it prohibits the person from carrying out activities of daily living.

Staff Secure Facility for Residential Treatment

Any setting which assures that all entrances and exits are under the exclusive control of the facility staff, and in which a child may reside for the purpose of receiving treatment.

State Citizen Foster Care Review Board

A state citizen board created by KRS 620.310 to review cases.

Status Offense Action

Any action brought in the interest of a child who is accused of committing acts, which if committed by an adult, would not be a crime. Such behavior shall not be considered criminal or delinquent and such children shall be termed status offenders. Status offenses shall not include violations of state or local ordinances which may apply to children such as a violation of curfew or possession of alcoholic beverages.

Substantiated (CPS)

- An admission of abuse, neglect, or dependency by the person responsible; or
- A judicial finding of child abuse, neglect or dependency; or
- A preponderance of evidence exists that abuse, neglect or dependency was committed by the person alleged to be responsible.

SWIFT

The mission of the swift adoption team is to expedite the achievement of a finalized adoption. This data is captured in TWIST swift screens and is used to help expedite each child to permanency.

Take Into Custody

The procedure by which a peace officer or other authorized person initially assumes custody of a child. A child may be taken into custody for a period of time not to exceed two hours.

Treatment, Payment and Health Care Operations (TPO) HIPAA Includes all of the following:

- Treatment - The provision, coordination, or management of health care and related services, consultation between providers relating to an individual or referral of an individual to another provider for health care;
- Payment - Activities undertaken to obtain or provide reimbursement for health care, including determinations of eligibility or coverage, billing, collection activities, medical necessity determinations and utilization review; and
- Health Care Operations - Includes functions such as quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, conducting or arranging for medical review, legal services and auditing functions, business planning and development and general business and administrative activities.

Unable to Locate

- Identifying information about the family is insufficient for locating them; or
- The family has moved and their new location is not known

Unsubstantiated

Means there is insufficient evidence, indicators, or justification present for substantiation of abuse, neglect, or dependency.

Universal Precautions

As defined by the Center for Disease Control (CDC), are a set of precautions designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other blood-borne pathogens when providing first aid or health care. Under universal precautions, blood and certain body fluids are considered potentially infectious for HIV, HBV and other blood-borne pathogens. The following web sites may be useful:

<http://www.cdc.gov/hai/>

<http://pediatrics.aappublications.org/cgi/content/abstract/101/3/e13>

Use (HIPAA)

Refers to, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

Valid Court Order

A court order issued by a judge to a child alleged or found to be a status offender:

- Who was brought before the court and made subject to the order;
- Whose future conduct was regulated by the order;
- Who was given written and verbal warning of the consequences of the violation of the order at the time the order was issued and whose attorney or parent or legal guardian was also provided with a written notice of the consequences of violation of the order, which notification is reflected in the record of the court proceedings; and

Who received, before the issuance of the order, the full due process rights guaranteed by the Constitution of the United States.

Violation

Any offense, other than a traffic infraction, for which a sentence of a fine only can be imposed.

Ward (APS)

A person for whom a limited guardian, guardian, limited conservator, or conservator has been appointed.

Wardship and Custody Order

Is a Circuit Court document necessary when both birth parents are deceased and the child is committed to the Cabinet through District Court and Termination of Parental Rights has not occurred.

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2016 Edition

Kentucky's Foster Parent Handbook