

CHAPTER 65C-13 SUBSTITUTE CARE OF CHILDREN

PART I LICENSING OF SUBSTITUTE FAMILY CARE

65C-13.001 Definitions.

65C-13.002 Private Agency Foster Homes.

65C-13.003 Pre-Service and In-Service Training.

65C-13.004 Initial Licensing Procedures for Foster Homes, Emergency Shelters and Group Homes.

65C-13.005 Changes During the Licensed Year.

65C-13.006 Relicensing Procedures.

65C-13.007 Respite Care.

65C-13.008 Prospective Foster Parent Inquiries.

65C-13.009 Parent Preparation and Mutual Selection.

65C-13.010 Substitute Care Parents' Role as a Team Member.

65C-13.011 Minimum Standards for Licensure of Family Foster Homes, Family Emergency Shelter Homes and Family Group Homes.

65C-13.012 Substitute Family Records.

PART II POLICIES AND PROCEDURES FOR SUBSTITUTE CARE

65C-13.013 Definitions and Glossary.

65C-13.014 Entry into Foster Case.

65C-13.015 The Prevention and Management of Sexual Assault in Foster Care.

65C-13.016 Health Care.

65C-13.017 Services for HIV Infected Children.

65C-13.018 Services to Parents of Children in Foster Care.

65C-13.019 Administrative Review.

65C-13.020 Permanency Staffings.

65C-13.021 Post-Placement and Protective Supervision.

PART I LICENSING OF SUBSTITUTE FAMILY CARE

65C-13.001 Definitions.

The following definitions describe the types of care that are addressed in this chapter of the manual:

- (1) "Family Foster Home" means a private residence in which children who are unattended by a parent or legal guardian are provided 24-hour care. Such homes include emergency shelter family homes, family foster group homes, and specialized foster homes for children with special needs. A person who cares for a child of a friend for a period not to exceed 90 days, a relative who cares for a child and does not receive reimbursement for such care from the state or federal government, or an adoptive home which has been approved by the department or by a licensed child-placing agency for children placed for adoption is not considered a family foster home. Exceptions may be made in order to keep siblings together. No more than two of the five children should be infants.
 - (a) Family foster homes are limited to five children, including the family's own children.
 - (b) Therapeutic foster homes are limited to two children.
 - (c) Individual residential treatment family homes are limited to one child.
- (2) "Foster Family Group Home" means a licensed private family home occupied by a married couple or individual who have demonstrated the interest and special qualifications to care for a total of no more than five pre-adolescent and adolescent children, including the family's own children. The family group home parent should be able to work in close cooperation with the department. Foster family group homes differ from a traditional foster family home in several respects:
 - (a) Group home must submit any requested written reports and carry out any designated treatment plans for the children in their care.

(b) Group home parents must sign the affidavit of civil rights compliance.

(c) Group work, individual casework, and psychiatric consultation are provided as needed to group homes to further the treatment objectives.

(3) "Emergency Family Shelter Homes" means a licensed private family home occupied by a married couple or individual who receive children on an emergency basis from the department. Emergency family shelter homes differ from the traditional foster family home in the following respects:

(a) Must be available to receive children on a 24-hour basis.

(b) Must sign the affidavit of civil rights compliance.

(c) Family emergency shelters are limited to caring for not more than five children. This includes the families own children.

(d) Must keep the register of children in emergency shelter family home log up-to-date.

(4) "Group Preparation and Selection – Model Approach to Partnerships in Parenting" is the pre-service training program selected by the department. References to this program throughout the rule will be by its initials GPS-MAPP.

- 192

Specific Authority 409.175 FS. Law Implemented 409.175 FS. History–New 5-27-92, Amended 7-18-95, Formerly 10M-6.015, Amended

11-30-97.

65C-13.002 Private Agency Foster Homes.

The department is responsible for the issuance of licenses to family foster homes approved by licensed child-placing agencies that operate throughout the state. Licensed child-placing agencies will receive the application and complete the foster home study. The private agency must certify in writing that the family meets the licensing requirements and request the department to issue the license. Responsibility for recruitment, assessment, training of staff and supervision of these homes rests with the licensed child-placing agencies. Responsibility for investigating complaints of family foster homes licensed by child-placing agencies rests with the department. Section 409.175, F.S., requires that all foster homes and agencies are inspected annually. The department will verify the agency's compliance with the licensing standards set forth in Chapter 65C-15, F.A.C., at the time of the agency's yearly relicensing study.

(1) Substitute care parents licensed through private agencies are not required by statute to attend mandatory pre-service or in-service training provided to department substitute care parents.

(2) The district responsible for licensing the child-placing agency will issue the family foster home license to the private agency home. If the home is located in a district other than the district where the child-placing agency is located, it will be the responsibility of the district program office to notify the district where the private agency home is located.

Specific Authority 409.175 FS. Law Implemented 409.175 FS. History–New 5-27-92, Formerly 10M-6.016.

65C-13.003 Pre-Service and In-Service Training.

Sections 409.175(13)(a), (b), F.S., requires the department to provide pre-service and in-service training for foster and emergency shelter parents who are licensed and supervised by the department as a condition of licensure.

(1) Pre-Service Training. Substitute care parents licensed by the department are required by statute to complete a minimum of 21 hours of training. This pre-service training must be uniform statewide. The department has selected a pre-service training

program for its prospective foster family parents, emergency shelter parents, group home parents and adoptive parents called Group Preparation and Selection, GPS-MAPP. This program provides 30 hours of pre-service training which is focused on parent preparation, education and mutual selection. The department will not offer any other program for use in preparing its prospective parents. During the GPS-MAPP program, prospective parents will be given a number of handouts to enhance their learning experience and for future reference. These handouts will not appear as attachments to this chapter. GPS leaders will have received training on the contents and use of these handouts during certification training at the Professional Development Centres. The handouts should be ordered from the warehouse in Jacksonville.

(2) In-Service Training. Section 409.175(13)(c), F.S., requires that prior to the renewal of a license, each foster parent, emergency shelter parent and family group home parent successfully complete eight hours of in-service training. This training shall include subjects affecting the daily living experiences of these families and should be appropriate to the need of the substitute care parents. Appropriate training may include, but not be limited to: CPR, child safety and injury prevention, sexual abuse, HIV infection, addictions, etc. If a parent chooses to obtain their in-service training hours through reading books or viewing videos, they must have the materials selected for the in-service training approved by staff prior to its use. The parents must also be able to demonstrate to staff that their knowledge and skills have been enhanced. Upon completion of the training, staff will issue the parent a certificate of completion. A copy will be retained in the licensure file. Parents will be reimbursed for travel and child care, as stipulated in the statute, from the district's expense funds. Travel will be reimbursed at the established rate set by the department for all travel and child care will be reimbursed at a reasonable rate consistent with expenses found locally. The statute specifically requires the department to:

- (a) Reimburse such parents for travel expenses to attend this training; and
- (b) To provide child care or reimburse the parents for baby-sitting expenses, if both parents attend the training. Single parents may also be reimbursed for baby-sitting expenses to attend this training.

Specific Authority 409.175 FS. Law Implemented 409.175 FS. History—New 5-27-92, Formerly 10M-6.017.

65C-13.004 Initial Licensing Procedures for Foster Homes, Emergency Shelters and Group Homes.

(1) The unit office submits to the district administrator or his designated representative a copy of the family portfolio, including all required forms. The study must be reviewed and signed by the prospective parent and certified GPS leader prior to submission to the GPS leader's supervisor for review.

(2) The district administrator or his designated representative will review the Family Portfolio, including the supporting documentation and either approve or reject the application.

(3) If approved, a license is issued in the name in which the application for a license has been made and is forwarded to the unit office for delivery to the substitute parents. Instructions for issuing a license may be found in Rule 65C-13.011, F.A.C., of this rule.

- 193

(4) A license is issued for a specific location, is not transferable, and is valid for one year from the date of issuance. The license

authorizes the home to provide care for children placed in the home by the department or licensed child-placing agency. A particular child, a specific number of children, or an age range for children may be displayed on the license in order to restrict the use of the home when the study indicates the necessity for such restrictions.

(5) The district will maintain a central file on every home licensed. A working file for licensing will be maintained in the unit

responsible for licensing studies. The location of the central files will be identified by the district.

Specific Authority 409.175 FS. Law Implemented 409.175 FS. History–New 5-27-92, Formerly 10M-6.018.

65C-13.005 Changes During the Licensed Year.

(1) If the district decides to discontinue the use of a home or revoke the license prior to the expiration date of the license, the

reasons for such action must be discussed with the substitute care parents. If they agree with the department's decision, the license

must be secured from them and sent to the district office along with a completed closing of foster home for dependent children

form. If the substitute care parents do not agree to relinquish their license then an administrative complaint must be filed by the

unit. The administrative complaint must be reviewed and signed by the district administrator or his designated representative in

accordance with the Administrative Procedures Act. When such situations occur staff should consult their district program office

and district legal counsel prior to filing an administrative complaint. If the administrative complaint results in the revocation of the

license the substitute care parents must return the license to the unit who will then complete the closing of foster home for

dependent children form. Both the license and this form will then be sent to the district office where the license will be cancelled. If

the substitute care parents voluntarily surrender the license and agree with the decision to terminate as substitute care parents, but

then change their mind, they have the right to request an administrative hearing and should be so advised.

(2) If a family changes its location during the licensing year, the new home must be evaluated and a new sanitation inspection

must be made by the local county public health unit. The certificate of license issued for the old location must be returned to the

district office, together with a relicensing summary for foster homes for dependent children completed on the new home, a copy of

the sanitation inspection report, and a recommendation with regard to the issuance of a license for the new address. An application

for a license must be signed by the substitute parents showing the new address. If approved, a new certificate of license will be sent

to the unit office for delivery to the substitute care parents.

Specific Authority 409.175 FS. Law Implemented 409.175 FS. History–New 5-27-92, Formerly 10M-6.019.

65C-13.006 Relicensing Procedures.

Section 409.175, F.S., stipulates that a license to care for children placed in the custody of the department or in the custody of a

licensed child-placing agency is valid for not more than one year from the date of issuance. Relicensing is accomplished as follows:

(1) The department must receive the report of an approved sanitation inspection from the local health program office. The

counselor must request the inspection in sufficient time to secure the report prior to the date the old license expires.

(2) The counselor should send the staff inquiry – annual relicensing study to all counselors who have had children in the home

for completion prior to the expiration of the license. This information is vital to assess the home.

- (3) Prior to the issuance of a new license, the counselor must secure Abuse Registry and law enforcement clearance for all adults who reside in the home following the procedures outlined in this rule.
- (4) The counselor must complete section A of the relicensing summary for foster homes for dependent children.
- (5) The substitute care parent must complete section B of the relicensing summary for foster homes for dependent children.
- (6) The substitute care parent must sign an application for a license form.
- (7) The counselor must meet with the substitute care family to review the relicensing summary for foster homes for dependent children and to formulate recommendations for relicensure.
- (8) The substitute care parents must have completed eight hours of in-service training. The number of hours of training, and type of training provided should be documented in the case file of the substitute parents.
- (9) At least two weeks prior to the date for relicensure copies of all forms, including the sanitation inspection, must be submitted to the district office with a request for the issuance of a new license.

Specific Authority 409.175 FS. Law Implemented 409.175 FS. History—New 5-27-92, Formerly 10M-6.020.

65C-13.007 Respite Care.

All persons who provide respite care in their own homes must be licensed pursuant to Section 409.175, F.S. If the family only

wishes to provide respite care they will have one year from the date the license is issued to complete the 30 hours of GPS-MAPP training.

- (1) All persons that provide respite care in the child's foster home, emergency shelter or group home on an overnight basis must be screened pursuant to Chapter 85-54, F.A.C. Training in the GPS-MAPP program for these providers should be strongly encouraged in order to assist them in providing quality care. If a respite care provider is unable or unwilling to attend the GPS-MAPP training they must receive an orientation which covers protocol for handling emergencies, confidentiality, the department's discipline policy and an overview of substitute care.

- 194

- (2) All respite care providers must be furnished with written information about each child they will care for such as:
 - (a) Phone numbers for a 24-hour response;
 - (b) Medical authorization;
 - (c) Physician name and phone numbers;
 - (d) School; and
 - (e) Medicaid number.

Specific Authority 409.175 FS. Law Implemented 409.175 FS. History—New 5-27-92, Formerly 10M-6.022.

65C-13.008 Prospective Foster Parent Inquiries.

The department will respond within 10 working days to all telephone and written inquiries about becoming a foster parent.

Following this initial communication, if the person making the inquiry continues to express an interest in providing foster care and they have no background history that would disqualify them from being foster parents, the department will send written orientation

information concerning foster parenting within 14 days of the initial inquiry.

Specific Authority 409.175 FS. Law Implemented 409.175 FS. History—New 7-18-95, Formerly 10M-6.0221.

65C-13.009 Parent Preparation and Mutual Selection.

- (1) Philosophy and Rationale. In January 1989 the department adopted the MAPP Group Preparation and Selection program for use in the preparation and selection of prospective shelter, foster and adoptive parents. The program provides a structured

format through which prospective parents can be prepared to work with department staff as team members in permanency planning.

This program was developed by the Child Welfare Institute and predicated on the beliefs that shelter, foster and adoptive parents need to be prepared prior to the placement of children in their homes and that they need to be prepared to work as partners in permanency planning.

(a) Experience has taught us that parent preparation work, pre-service training, with prospective parents reduces disruptions, length of time a child is in placement and parent burnout and turnover. Prepared parents are not only less likely to request a child's removal, but they are more likely to be a resource for children who have a wider range of special needs or problems. They are also more likely to enable children to move out of foster care placement into permanent placements.

(b) Because shelter and substitute care parents have round-the-clock close contact with the children in their homes, they have the most influence on the children's adjustments in care, their relationship with the birth parents, and their ability to move successfully into an adoptive placement or other permanent placement. Therefore, parents must work effectively as team members.

Prospective parents need a complete understanding of this role and the rights and obligations that accompany that status.

Additionally, they need guidelines to function as partners in the delivery of services – fulfilling tasks as diverse as helping a child go home or becoming that child's adoptive parent.

(c) The GPS-MAPP program has been designed to include the home study process along with the parent preparation work. The approach is one of shared decision making, problem solving and mutual selection, all of which are integral to building mutual trust and teamwork. The GPS-MAPP program is delivered through ten preparation sessions and is designed to enable participants to develop a knowledge base, attitudes and skills to effectively provide care to children placed in their homes by department staff.

(d) The department's parent preparation program is based on the following assumptions or beliefs:

1. Every child regardless of race, age, sex, physical and emotional health, and intellectual ability, is entitled to a continuous relationship intended to be permanent.

2. For most children, the birth family provides the best environment.

3. When a child's family is not able or willing to care for her or him, then substitute care should be provided as a service both to children and their families.

4. Substitute care is a family protective service in which every reasonable effort must be made to expeditiously reunite children and parents according to a casework plan.

5. Substitute care does not provide children with the continuity, commitment, legal status and social status necessary for

growth and development. It is only a process or a service used to facilitate family reunification, prepare children for adoptive placement, or prepare youth to move into self-sufficient independent living.

6. Shelter and substitute care parents are involved in carrying out two simultaneous roles: parenting and substitute parenting.

Parenting tasks require general child care that any birth parent would provide. Substitute parenting tasks require a commitment to

permanency planning and involves working in partnership with the department, courts, birth and adoptive parents. The permanency

planning role needs to be developed through a preparation or mutual selection program.

7. For most children who cannot return home, adoption provides the best family environment.
8. Substitute care parents often are the most desirable adoptive parents for children who have formed strong attachments to them.
9. Substitute care parents can best be considered as adoptive parents if they have been prepared first to make a commitment to keeping siblings together and to family reunification.
10. Substitute care and adoption service delivery requires the integration of all members – especially counselors, shelter, foster and adoptive parents – into a partnership to achieve a common goal: permanence for children.

- 195

11. Partnership, or teamwork, is a skill to be learned and practiced. Parents can be more effective if they are prepared prior to the placement of a child.

(e) The goal of the Group Preparation and Selection Program is to prepare individuals and families to make an informed decision about becoming foster or adoptive families. The decision is made with the department and is based on the capability and willingness to take on the “role” and develop the skills needed to foster or adopt. Foster and adoptive families who make good decisions and grow in their new roles work best with the department, birth families and others. These partnerships help children and youth have stability and permanence with a family. As successful foster and adoptive parents you must be able to:

1. Know your own family. Assess your individual and family strengths and needs; build on strengths and meet needs.
2. Communicate effectively. Use and develop communication skills needed to foster or adopt.
3. Know the children. Identify the strengths and needs of children and youth who have been abused, neglected, abandoned, and/or emotionally maltreated.
4. Build strengths; meet needs. Build on strengths and meet needs of children and youth who are placed with you.
5. Work in partnership. Develop partnerships with children and youth, birth families, the department, and the community to develop and carry out plans for permanency.
6. Be loss and attachment experts. Help children and youth develop skills to manage loss and attachment.
7. Manage behaviors. Help children and youth manage behaviors.
8. Build connections. Help children and youth maintain and develop relationships that keep them connected to their pasts.
9. Build self-esteem. Help children and youth build on positive self-concept and positive family, cultural and racial identity.
10. Assure health and safety. Provide a healthy and safe environment for children and youth and keep them free from harm.
11. Assess impact. Assess the ways fostering and/or adopting will affect your family.
12. Make an informed decision. Make an informed decision to foster or adopt.

(2) Purpose of Participation in Group Preparation and Selection.

(a) While participating in the parent preparation group the prospective parents will be provided comprehensive information on

the substitute care and adoption programs. At a minimum this will include the following:

1. The definition and goals of substitute care and adoption;
2. The difference between providing substitute care, an adoption placement and parenting one’s own child;
3. The problems which necessitate a child being placed in substitute care;
4. The characteristics of children needing family foster care placement, including strengths and needs;
5. The characteristics of birth parents, including their strengths, needs, rights and responsibilities;
6. The roles and responsibilities of substitute care parents and adoptive parents to the child, to the birth parents, to the

department and to their own family;

7. The roles and responsibilities of the department to the foster family, adoptive family and the birth family, including the children;

8. The impact of substitute care and adoptive home placement may have on the applicant's own family;

9. The impact that separation and placement has on the child, the birth family, substitute care family and adoptive family;

10. The nature and purpose of performance agreements, and permanent placement plans; and

11. The minimum standards for foster family care, and adoptive home placement as stated in Administrative Chapter 65C-13, F.A.C., and department policy.

(b) The prospective substitute care and adoptive family will have an opportunity to assess their family's potential for parenting

children placed by the department, as well as to determine the number and characteristics of children best suited for their family.

(c) Prospective families will receive training for the job of substitute care and adoptive home placement parenting as they

choose whether or not they would like to be licensed or approved.

(d) The certified GPS leaders will have an opportunity to assess the family's potential for parenting, including the number and

characteristics of children best suited for the home, and to ensure that the family meets the minimum standards for foster family care and adoptive home care.

(3) Qualities to Discuss with Prospective Substitute Care and Adoptive Families. The following characteristics and behaviors

should be discussed with each prospective parent. These characteristics and behaviors will be assessed through discussions and

participation in the group meetings, through information provided as part of the family portfolio by prospective family members

and through interviews with the family.

(a) Characteristics of substitute care and adoptive parents:

1. Tolerance;

2. Flexibility;

3. Ability to solve problems;

4. Ability to assume responsibility for their own behavior;

5. Ability to learn and implement new ideas;

6. Ability to make independent decisions;

7. Perseverance;

8. Ability to delay gratification;

9. Innovativeness;

- 196

10. Willingness to risk;

11. Ability to empathize;

12. Compassion;

13. Ability to work with the department; and

14. Ability to accept persons and lifestyles different from their own.

(b) Behavioral reactions to emotions:

1. Anger;

2. Frustration;

3. Grief, sadness, depression;

4. Happiness;

5. Love;

6. Pride;

7. Ambivalence;

8. Guilt; and

9. Fear.

(c) Communication skills:

1. Ability to let you know where they stand; and
2. Listening skills, for example, eye contact and responses which encourage additional conversation.

(d) Parenting skills:

1. Have they enjoyed being a parent, or if they have no children, have they enjoyed their experiences with children? How have they demonstrated their interest in children in the past?
2. Can they accept and understand the individual needs of a child and how these may differ from those of their own child?
3. Do they have the capacity to accept the child's relationship with his parents and with the department?
4. Can they accept working with the department to determine the most appropriate permanency planning goal for a child and agree to participate as a team member in working toward achieving the goal?
5. Do they have the perseverance to see a child through to the end of his temporary care placement in order to provide continuity to the child?

(4) Method of Group Preparation and Selection.

(a) Prospective parents will be enrolled in a 10-week course of study that includes mutual selection, at least two family

consultation visits and the preparation of a family portfolio. Material and activities have been developed to engage the participants in a learning experience that enhances their knowledge base and skills. Prospective parents will be required to participate in ten

weeks of training, generally, three hours – one night a week, provide requested information that will become a part of the family

portfolio, and meet all regulatory requirements and participate in at least two family consultation visits. Each group will be jointly

led by two certified leaders, one staff member and an experienced parent. The role of the parent co-leader includes the following

responsibilities: co-leading the training activities, screening of prospective parents, conducting the initial family consultation visit,

whenever possible and appropriate, and assisting in the preparation of the family portfolio.

(b) If there are so few applicants available for study that it would be impractical to conduct a group, an individual study may be

completed with the approval of the district program office. On occasion, good casework practice would dictate the department

completing such a study to expedite a child's placement. In these cases, staff must also request approval from the district program

office to expedite the study. If an individual home study is done, the certified GPS leader is responsible for ensuring that all

material contained in the GPS-MAPP program is discussed with the family and that copies of all handouts and reading materials are provided.

(c) Prospective parents need to be screened prior to being invited to participate in a parent group through the use of a telephone

inquiry form. The purpose of this screening is not to eliminate prospects but to ensure that these potential applicants have a good

understanding of the children who are in need of service within the district. In order to do this effectively, staff must be familiar

with the children waiting placement. After appropriately screening prospective parents, staff need to determine which upcoming

group would be most appropriate and convenient for the family.

(d) The culmination of the ten weeks of training is the joint preparation of the family portfolio by the prospective parents and

the certified leaders. The portfolio is submitted for review and approval to the district administrator, or his designated

representative. The family portfolio is the total collection of information designed to document and consolidate the entire preparation and selection process for each foster or adoptive family. A family portfolio may be organized in many different ways. It is suggested that the contents include: decision page, approval or disapproval related to criteria for selection; partnership profile, summary or recommendations and family profile; references; professional development plan; medical records, other records and checklists; strengths or needs notes; notes from family consultations; narrative process notes; partnership development plan; and recertification information. Supporting documentation submitted along with the portfolio includes the application for license; copies of personal references; a substitute care school reference, as appropriate; copies of the criminal record and abuse registry clearances for all adults living in the applicant's household; a copy of the sanitation report; copy of the Early Periodic Screening Diagnosis and Treatment Agreement; and an agency reference form, as appropriate.

(5) Requirements for Prospective Parents. Prospective parents must:

- 197

(a) Attend ten meetings, a minimum of 30 hours, of pre-service training. Families may not miss more than two sessions. Under only rare circumstances can they miss meeting three or four. If these specific meetings are missed, the family must make up the sessions and demonstrate an understanding of the material. In situations where an individual foster home study is completed, the prospective foster parent must demonstrate an understanding of the pre-service materials and handouts.

(b) Complete a family portfolio.

(c) Sign an application for license.

(d) Sign a confidentiality statement.

(e) Meet minimum standards for shelter and foster family care as found in Administrative Chapter 65C-13, F.A.C., and department policy.

(6) Requirements for Department of Children and Family Services Staff.

(a) The certified GPS leader, staff and parents, must:

1. Provide pre-service training for prospective shelter, foster and adoptive families.

2. Conduct at least two family consultation visits with each family. The substitute family should be advised that the department

can and may make unannounced visits to their home if determined necessary.

a. At least one visit must include the entire family.

b. It is recommended that the first visit be scheduled after the third meeting and the second after the tenth meeting. If it is

necessary to complete an individual home study, there must be at least two home visits with the family.

c. A minimum of two visits to neighbors who know the substitute parents is required. These visits can usually be conducted at the time of the home visits.

3. Obtain three written personal character references which must include at least one reference from school personnel, when

there are school age children in the applicant's family. These references may not be related to the person being screened. Persons

asked for character references should know the person being screened and be able to comment on their good moral character and

have known the person for at least two years.

4. If the applicants were ever licensed or certified by another agency within Florida or by an agency outside the state, a written

request for a reference is required. The request for a reference can ask for additional information as appropriate, such as a request

for a copy of the home study or last relicensing study. Within a reasonable amount of time if there is no response then a telephone inquiry should follow. This as well as all other efforts and information obtained should be clearly documented in the licensing study.

5. Request a criminal records check for all persons age 18 and older residing in the prospective home, using the following

procedures:

a. Have each adult sign a release of information and consent to law enforcement and abuse registry record check.

b. Complete a one-time employment history check. This check shall be over a two-year period of time preceding the family's

application to provide care and excluding periods of unemployment.

c. Complete request for criminal history record check.

d. Submit request to the Florida Department of Law Enforcement.

6. Request Abuse Registry clearance for all persons age 18 and older residing in the prospective home. The following

procedures should be used to procure an Abuse Registry clearance:

a. Provide the following information on each adult residing in the home: name, race, sex, date of birth, social security number,

name of any previous spouse, and names of all children.

b. Submit request for Abuse Registry clearances to the district background screening unit for processing.

7. Request a sanitation inspection by the local health program office for the prospective home being considered for licensing.

(b) Screening. According to Section 409.175, F.S., screening means the act of assessing the background of personnel and

includes, but is not limited to, employment history check, check of references, local criminal records check through local law

enforcement agencies, fingerprinting, statewide criminal records check through the Department of Law Enforcement, federal

criminal records through the Federal Bureau of Investigation and abuse registry clearance. The

implementation of the screening

policies and procedures and the determination of good moral character is the responsibility of the district screening coordinator.

The district screening coordinator works closely with the district licensing counselor to ensure compliance with the statute.

(c) Local Criminal Records Checks. The local criminal records check is completed yearly through the sheriff or police

department located in the community in which the applicant resides. Unless the applicant has lived in the current jurisdiction at

least six months, the screening is also conducted for the applicant's previous residence. The licensing program is responsible for

coordinating the local criminal records clearance through the district screening coordinator.

(d) State and Federal Checks. The state criminal records checks are completed every five years and the federal criminal records

check, fingerprints, are only done one time at the initial licensing. General information about this screening is as follows:

1. Fingerprints are taken by official law enforcement personnel, Department of Children and Family Services personnel or

local licensing employees trained for the purpose.

2. The cost for processing fingerprint cards for families interested in providing family foster care, family emergency shelter

care or family group care is assumed by the department.

3. Fingerprint cards are submitted directly to the department for handling.

4. The disposition of the state and federal criminal records check is the responsibility of the district screening coordinator. The coordination procedures of the disposition results may vary from district to district. Licensing staff must work closely with their screening coordinators to ensure the disposition information is received in a timely manner in order to take action on the licensing application.

(e) Abuse Registry Checks. Abuse Registry checks are obtained annually for all family foster homes, family emergency shelters and family group homes.

(f) Affidavit of Good Moral Character. All applicants for licensing must complete the affidavit for good moral character attesting to their own good moral character. This is a "one time" document completed at the time of initial licensing.

(g) Delinquency Checks. This is a one-time only check which is obtained on the children of the prospective substitute care parents, emergency shelter parent or family group home parent who has children over the age of 12 residing in the home. These records are obtained by completing and forwarding the Florida protective services system background check, to the district screening coordinator.

(h) Employment History Checks and Checks of References. A one-time employment history check is to be completed for all substitute parents. This shall be over a two-year period preceding the family's application for license. If periods of unemployment have occurred during the two-year period, the employment history check will exclude periods of unemployment.

(i) Radon Testing. Chapter 404, F.S., requires testing for radon gas for all substitute care homes that are state licensed.

Retesting of substitute care homes for radon gas must take place every five years.

(7) Content of Preparation and Selection Training. The district should adhere to an annual training schedule for conducting parent preparation groups. It may be necessary for leaders to adjust the following schedule somewhat to meet local needs throughout the year. All materials found in the GPS-MAPP program must be covered and activities completed.

(a) Prior to Meeting One.

1. Screen telephone inquiries and complete inquiry forms. Discuss shelter, foster care and adoption and the mutual selection and preparation process. Assess eligibility to participate in the GPS-MAPP program. Collect data on effectiveness of recruitment efforts.

2. Call families indicating an interest and confirm their participation in an upcoming group.

3. Make every effort not to exceed 10-15 family units in a group. This includes singles as well as couples, each being considered a family unit. A group will not exceed 30 individuals without prior authorization by the district MAPP coordinator.

(b) During First Week.

1. Welcome to the Group Preparation and Selection Program: Activities acquaint participants with the program and each other; explain the preparation and mutual selection process; discuss the shelter, foster care and adoption programs; outline and discuss the roles, responsibilities and rewards of providing substitute care and adoptive home placement.

2. Distribute application and profile.

3. Identify each family's strengths and needs.

4. Begin gathering regulatory information, i.e., affidavit of good moral character, release of information and consent to law

enforcement and abuse registry record check, and FPSS Background Check.

5. Display waiting children, i.e., photolisting, bulletin board, brochures, etc.

6. Conduct assessment and planning meetings with co-leaders. Compile meeting notes.

7. Distribute the following handouts: meeting agenda; criteria for mutual selection; description of group preparation and

selection program; strengths and needs work sheet; family profile; partnership development plan; bill of rights for children in foster

care; rights of parents of children in foster care; important definitions; effective communication; group preparation and selection;

rights, responsibilities and rewards of substitute or adoptive parents and counselors; medical, legal and financial information for

substitute and adoptive parents; mandatory reporting of abuse or neglect; and emergency shelter care.

(c) During Second Week.

1. Where the MAPP Leads – A Foster Care and Adoption Experience: Overview provided of a substitute care and adoption

experience from the perspective of the client, children and families, substitute care parents, adoptive parents and counselors;

materials and activities demonstrate the stresses and losses that can lead to a placement out of the home; discuss what happens if a

placement does not work out; discuss how families are reunited; discuss how children are placed in an adoptive home; and discuss

how some youth move into independent living.

2. Gather completed family profiles and schedule family consultation visits after meeting three.

3. Continue gathering regulatory information indicated in this chapter.

4. Contact families who did not return.

5. Display waiting children.

6. Conduct assessment and planning meetings with co-leaders. Compile meeting notes.

7. Distribute the following handouts: meeting agenda; substitute care intake process; steps to termination of parental rights;

agency policy on foster parent adoptions; group 1 work sheet – adopting substitute care parents; group 2 work sheet – new adoptive

family; group 3 work sheet – foster family giving Lillie up to an adoptive family; group 4 work sheet – how Lillie sees her needs in

two different adoption possibilities; planning a move; independent living scenario; and strengths or needs work sheet.

(d) During Third Week.

- 199

1. Losses and Gains: Explores the impact of separation on the growth and development of children and the impact on substitute

care and adoptive placement on the feelings and behaviors of children and parents. Personal losses, death, divorce, infertility,

children leaving home, are examined and the effect of difficult life experiences on the success of parents. Emphasis is placed on the

partnership roles of parents and counselors as they work together to turn separation losses into gains.

2. Gather completed family profiles and schedule family consultation visits.

3. Continue gathering regulatory information indicated in this chapter.

4. Contact families who did not return.

5. Display waiting children.

6. Conduct evaluation and planning meeting with co-leaders. Compile meeting notes.

7. Distribute the following handouts: meeting agenda; indicators of expected development and warning signs; grieving process

work sheet; impact of children's losses on substitute care parents and adoptive parents; strengths and needs work sheet; and

strengths and needs work sheet for fertility loss experts.

(e) During Fourth Week.

1. Helping Children with Attachments: Explores attachment and child development. Focuses on how attachments are formed and the special needs of children, especially in the areas of building self-concept and appropriate behavior. Discuss partnership

roles of parents and counselors in helping children form new attachments.

2. Prepare for meeting 9 panel – invite panel members.

3. Gather completed family profiles and schedule family consultation visits.

4. Continue gathering regulatory information indicated in this chapter.

5. Contact families who did not return.

6. Display waiting children.

7. Conduct evaluation and planning meeting with co-leaders. Compile meeting notes.

8. Distribute the following handouts: meeting agenda; positive interaction cycle; developing positive attachments between

parents and children, helping the premature infant or prenatally drug exposed baby attach and develop; strengths or needs work

sheet; and bonding and attachment.

(f) During Fifth Week.

1. Helping Children Learn to Manage Their Behaviors: Discuss techniques for managing behavior with an emphasis on

alternatives to physical punishment. Topics include special issues on discipline for children who have been physically, emotionally

or sexually abused or neglected. Techniques to be discussed include being a “behavior detective,”

reinforcement, time out, mutual

problem-solving, structuring and setting limits, negotiating and contracting.

2. Gather completed family profiles and schedule family consultation visits.

3. Continue gathering regulatory information indicated in this chapter.

4. If the leader learns that a parent has or had a disease, injury or condition that could hinder their ability to be a substitute care

parent or adoptive parent then the parent must provide a written statement from a physician regarding the family’s general health,

freedom from communicable disease, specific illnesses or disabilities and how these would affect their ability to parent.

5. Contact families who did not return.

6. Display waiting children.

7. Conduct evaluation and planning meeting with co-leaders. Compile meeting notes.

8. Distribute the following handouts: meeting agenda; impact of placement on self-concept; side effects of physical

punishment; agency policy on use of physical punishment; discipline methods; discipline methods – assessment work sheet; Lillie

and strengths and needs work sheet.

(g) During Sixth Week.

1. Helping Children with Birth Family Connections: Examines the importance of the birth family to the child in placement;

how to support positive feelings and contacts between children and their previous families. Considers special issues like how to

help children understand their backgrounds, what happens when there is no contact between children and

their families, and how to

support feelings and contacts between children and previous foster families, group home friends or adoptive families.

2. Gather completed family profiles and schedule family consultation visits. Complete initial consultation for families in which

there are significant concerns.

3. Continue gathering regulatory information indicated in this chapter.

4. Contact families who did not return.

5. Display waiting children.

6. Conduct evaluation and planning meeting with co-leaders. Compile meeting notes.
7. Distribute the following handouts: meeting agenda; identity; explanation; life book; fantasy; visit; visiting Dad; foster and adoptive parents' guide for successful visits or contacts; strengths or needs work sheet; importance of birth parents to children in foster care; and letter to the birth parents.

(h) During Seventh Week.

- 200

1. Gains and Losses: Helping Children Leave Foster Care: Discuss family reunification as the primary case planning goal as well as alternatives like foster care, adoption and independent living. Examines disruption and its impact on children, families and department staff. Also focuses on the partnership role of counselors, substitute care parents and adoptive parents in stabilizing placements.

2. Schedule family consultation visits.

3. Send letters to Meeting Nine panel members confirming date, time and place.

4. Develop list of guest participants for Meeting Nine; include ages of children.

5. Contact families who did not return.

6. Display waiting children.

7. Conduct evaluation and planning meeting with co-leaders. Compile meeting notes.

8. Distribute the following handouts: meeting agenda; Merrilee's case; planning a move – family reunification; planning a move – adoption; planning a move – from foster home to foster home; planning a move – from foster home to independent living;

five steps for disengagement work; disruptions – causes, partnership, preventions and interventions; stages of disruption; referral

list for adoptive parents; a youngster's story; disruption – foster mother's point of view; disruption – another foster mother's point

of view; a letter to some friends; questions for family and group discussion; and strengths or needs work sheet.

(i) During Eighth Week.

1. Understanding the Impact of Fostering or Adopting: In previous meetings, participants have discussed and "felt" what foster care and adoption are all about. Discussions have included such topics as separation and attachment, building and maintaining relationships with children, and working with children on how to deal with their feelings about the important people in their lives.

The roles of both substitute care parents and adoptive parents have been explored and the impact they have on the lives of children

and their families. During the meeting participants will look at how all of this effects foster and adoptive families. How will this

affect their marriage, children, relatives, friends, job and income?

2. First family consultation visit should be compiled by this week. Applicant should sign application at the time of last visit.

3. Finalize list of guest participants for Meeting Nine.

4. Contact families who did not return.

5. Display waiting children.

6. Conduct evaluation and planning meeting with co-leaders. Compile meeting notes.

7. Distribute the following handouts: meeting agenda; characteristics of the family system; ecomap to draw; first day; effects of

foster care – skit one; effects of foster care – skit two; effects of foster care – skit three; effects of foster care – skit four; effects of

foster care – role play; effects of adoption on marriage; and strengths or needs work sheet.

(j) During Ninth Week.

1. Perspectives in Foster Parenting and Adoptive Parenting: This meeting is open to all members of the family, especially the children, grandparents, and close friends. Anyone who plays a major role in the foster family or adoptive family needs to be invited.

At this meeting guest foster and adoptive families will be featured. These guests will share their personal experiences. Some of

those may include: impact on marriage and family, visiting parents, discipline, search, helping children with family reunification, and making adoptions work.

2. Have panel discussion for participants, their families and friends.

3. Schedule family consultation visit, if needed. Applicant must sign application at the time of the last home visit unless there are additional issues that need to be addressed.

4. Contact families who do not return.

5. Display waiting children.

6. Conduct evaluation and planning meeting with co-leaders. Compile meeting notes.

7. Distribute the following handouts: welcome game; meeting agenda; strengths or needs work sheet; strengths or needs

assessment for prospective adoptive parents; strengths or needs assessment for prospective substitute care parents; and strengths or

needs assessment for participants who have decided not to foster or adopt.

(k) During Tenth Week.

1. Endings and Beginnings: This meeting has several important tasks. First, some guidance about how teamwork will be

shared. Second, prospective substitute care parents will meet together and adoptive parents will meet together. In these groups, parents will have an opportunity to assess their strengths and needs.

2. Schedule final family consultation visit. Get applicant to sign Application at this visit. Review letter written for a birth

parent. Review scrapbook. Review Partnership Development Plan. Review ecomap. Make recommendations for approval.

Mutually create the Professional Development Plan. Modify the profile if necessary.

3. Complete gathering regulatory information indicated in this chapter.

4. Complete written summary and recommendation. Compile completed family portfolio and partnership profile. Send copy of

summary and recommendation to family. Send copy of professional development plan to family. Refer families for placement of child.

5. Review progress with Professional Development Plan. Inform families of in-service training programs, support groups and other resources.

6. Display waiting children.

- 201

7. Conduct evaluation and planning meeting with co-leaders. Compile meeting notes.

8. Distribute the following handouts: meeting agenda; emergency shelter and foster parent support and resource guide;

adoptive parent support and resource guide; final evaluation of the group preparation and selection program; and the professional development plan.

(8) Guidelines for Completion of a Family Profile and Summary and Recommendations.

(a) The family profile should be completed by the prospective shelter, foster or adoptive family, with assistance of the leader as required.

(b) The summary and recommendation should be completed by the leader in collaboration with the prospective family. The

family must be given an opportunity to read, sign, date the study, and provide written comments.

(9) Evaluation Assessment. Following each GPS group, the district MAPP coordinator needs to send each participant an evaluation to assess their experience. This feedback will enable the district to monitor its parent preparation work on an ongoing basis and take corrective action as needed.

Specific Authority 409.175 FS. Law Implemented 409.175 FS. History—New 5-27-92, Formerly 10M-6.023.

65C-13.010 Substitute Care Parents' Role as a Team Member.

(1) Responsibilities of the Substitute Parent to the Child.

(a) General.

1. To give love, acceptance, and care to a child without expecting a demonstration of appreciation from the child.
2. To provide the child with opportunities for normal growth and development.
3. To make a commitment to keep the child for a planned period of time.
4. To assist in preparing the child for return to the parents or permanent placement.

(b) Family Care Activities.

1. Daily living tasks.

- a. The substitute care parents are expected to provide structure and daily activities designed to promote the individual physical, social, intellectual, spiritual, and emotional development of the children in their home.
- b. The substitute parents should assist the children in performing tasks and developing skills which will promote their independence and the ability to care for themselves.
- c. The substitute care parents are expected to help children in their care to maintain a sense of their past and a record of their present.
- d. The substitute care parents should ask children in care to assume household chores reasonable for their age and ability not to exceed those expected of their own children.

2. Food and Nutrition.

- a. The substitute care parents must provide nutritionally balanced meals and age appropriate snacks.
- b. The substitute care parents are expected to provide for any special dietary needs of foster children placed in their home.

3. Clothing and Personal Belongings.

- a. All children should be provided with their own clean, well-fitting, attractive clothing appropriate to their age, sex and individual needs, in keeping with community standards and appropriate to the season.
- b. Each child must be provided his own towel, washcloth, and toiletry items such as toothbrush, comb, and hairbrush.
- c. All children must be allowed to bring, retain and acquire personal belongings while in care. Substitute parents must help each child protect and preserve possessions which are important to the child.
- d. When the child leaves the family home the substitute care parents must send along with him all serviceable clothing and personal belongings bought for, earned or given to the child. This includes any toys, bicycles, radios, or other things that are the child's personal belongings.

4. Religion and ethnic heritage.

- a. The substitute care parents must recognize, encourage, and support the religious beliefs, ethnic heritage, and language of a child and his family.
- b. Substitute parents are expected to arrange transportation to religious services or ethnic events for a child whose beliefs and practices are different from their own.

5. Discipline.

- a. The substitute care parents must discipline children with kindness, consistency, and understanding, and with the purpose of

helping the child develop responsibility with self-control.

b. The substitute care parents must help each child learn that he is responsible for his behavior by teaching him the natural and learned consequences of his behaviors.

c. Substitute care parents should use positive methods of discipline, including the following:

(I) Reinforcing acceptable behavior.

(II) Verbal disappointment of the child's behavior.

(III) Loss of privileges.

- 202

(IV) Grounding, restricting the child to the house or yard, or sending the child out of the room and away from the family activity; and

(V) Redirecting the child's activity, for example, if a child is playing with a sharp object take the object away, and replace it with a safe toy.

d. The substitute care parents must not allow children in care to be subjected to verbal abuse, derogatory remarks about themselves and family members or threats of removal from the home.

e. The substitute care parents must not subject children to cruel, severe, humiliating or unusual punishment, for example, to use

soap to wash out the mouth, eating hot sauces or pepper, placing in hot water, kneeling on stones, etc.

f. The substitute care parents must not use corporal punishment of any kind.

g. The substitute care parent must not delegate discipline or permit punishment of a child by another child or by an adult not known to the child.

h. The substitute care parents must not withhold meals, clothing, or shelter as a form of punishment.

i. The substitute care parents must not punish children for bed wetting or errors which occur during the toilet training process.

j. The substitute care parents must not resist implementation of the performance agreement, or permanent placement plan as punishment for misdeeds of a child.

k. The substitute care parents must not deny a child contact or visits with his family as punishment.

l. Substitute care parents may assign chores as the consequence of misbehavior, although these chores must not involve

physical exercise so excessive as to endanger the child's health, or so extensive as to impinge on time set aside for school work, sleeping, or eating.

m. The substitute must not threaten a child with removal or with a report to authorities as punishment for behavior. Threatening

the child with removal plays into the child's conviction that they are doomed to a series of placements and rejections. The

counselor's first task is to identify the child's specific behaviors which are causing the substitute parent to request the child's

removal. Once problems are identified the counselor along with the substitute parents and child assess ways to correct the problem.

If problems are not corrected and the substitute family continues to request removal, a conference should be held by the counselor

with the substitute family and child to discuss the possibility of removal and replacement. Involving the child in the planning may

help him feel he has some control of his life.

6. Health Care.

a. The substitute care parents are expected to maintain the child's resource record and take the responsibility to see that record

accompanies the child to every health care encounter and that the record is kept current. The child's resource record must

accompany the child when he leaves the substitute family.

b. The substitute care parents are expected to transport children for medical, dental or other appointments which may be needed. They are to remain with the child if needed for support and reassurance. Shelter parents will not be expected to transport for this care.

c. The substitute care parents must inform the counselor of medical and dental treatment of children, and keep clear records of these treatments.

d. The substitute care parents must immediately report to the department any serious changes in the health or mental health of a child.

e. The substitute care parents must coordinate with the counselor in making appointments for periodic EPSDT screening and ongoing medical services.

7. Medicine.

a. The substitute care parents must be responsible for dispensing the medication as prescribed by the physician and recording the exact amount of any medication prescribed for a child by a physician or dentist.

b. The substitute care parents must inform the department within one working day of any drugs prescribed for the child.

c. The substitute care parents must inform the department immediately of any prescription drugs taken by a child which were not prescribed for him and must secure emergency medical care if this is indicated.

d. All medication must be stored in a safe place which is not accessible to the children.

8. Recreation and community.

a. The substitute parents are expected to provide opportunities for recreational activities for the children. The activities must be appropriate to the child's age and abilities.

b. The substitute care parents must encourage children to take part in community services and activities both with the foster family and on their own.

9. Education.

a. The substitute care parents must enroll each child of school age in school within three school days of the child's placement.

The counselor must be sure that the child has been withdrawn from his previous school so enrollment can be speedily executed.

b. The substitute care parents are expected to take part in the selection and arrangements for educational programs which are appropriate to the child's age and abilities.

c. The substitute care parents must participate in the child's school activities, including regular teacher conferences.

d. The substitute care parents are expected to keep the counselor informed of educational plans, activities, school problems and the educational progress of the child, and to keep records of the same.

- 203

e. At no time are substitute care parents to give schools permission to paddle children. If the school requires further clarification of department rules, substitute care parents should refer them to the counselor.

(c) Substitute Parent Responsibilities.

1. Substitute care parents are expected to work cooperatively with the counselor as a member of a treatment team in seeking counseling, participating in consultation, and preparing and implementing the performance agreement or permanent placement plan for each child.

2. The substitute parents must provide pertinent information for judicial review hearings and administrative review

conferences for children placed in their home.

3. The substitute care parents are expected to maintain records in accordance with the department's procedures for the children placed in their home. The records must include:

- a. Child's name and age;
- b. Names, addresses and telephone numbers of persons who have authority to place and supervise the child in the home and who have authority to give medical consent in case of emergency;
- c. Names and addresses and telephone numbers of the child's parents and significant relatives, if appropriate;
- d. The date of arrival and departure of the child from the home;
- e. Maintain the child resources record including the medical passport;
- f. Progress notes on those areas of the child's performance agreement or permanent placement plan in which the substitute care parents are included, if applicable;
- g. Dates and duration of family visits, if applicable;
- h. School reports, if applicable;
- i. Developmental reports, if applicable;
- j. Records and notations in regard to the child's participation in clubs, organizations and other significant activities, if applicable, and;
- k. Pictures of the child, for example, school pictures, pictures of family outings, visits with siblings and parents, and vacations, if applicable.

4. The substitute care parents must maintain the children's records in a secure manner which insures confidentiality for the child and the biological parents.

5. The substitute care parents must accept the child as a member of their family, and accord the child the rights and responsibilities appropriate to his age and level of maturity.

6. The child must be assisted in understanding and accepting who he is, and helped to deal with any feelings about his biological family and the circumstances which brought him into care.

7. The substitute care parents must prepare the child to leave their family, whether the move is to the child's biological family, to an adoptive family, to a foster home, or to a residential setting, and must participate in and support the placement process.

(2) Responsibilities of the Substitute Care Parents to the Child's Family.

(a) The substitute care parents must present a positive image of and demonstrate respect for the child's own family and must agree to maintain a working relationship with the child's family members as indicated in the performance agreement or permanent placement plan.

(b) The substitute care parents must participate in planning visits for the child with his parents and family members.

(c) The substitute care parents must allow children and their family members to communicate by mail and by telephone in accordance with the child's performance agreement, or permanent placement plan.

(d) The substitute care parents are expected to share as many parenting experiences as possible with the child's own family, for example, participating in school conferences and activities, transporting the child to medical appointments, buying clothing, and attending birthday parties.

(e) The substitute care parents must never be openly critical of the child's biological family to the child or to others. Negative experiences and feelings should be shared with the counselor in a private setting.

(f) The substitute care parents must willingly share information about the child, his development, school progress, behavior, and any significant happenings with the counselor and with the biological family.

(3) Responsibilities of the Substitute Care Parents to Their Own Family.

(a) The substitute care parents must involve their entire family in the decision to become a shelter or foster family.

(b) The substitute care parents must prepare their own family for potential problems involved in providing family shelter or foster care.

(c) The substitute care parents must involve their entire family in each placement decision.

(d) The substitute care parents must discuss their decision to open their home to children with significant extended family.

(e) At the time of relicensure the entire family of the substitute care parents should join with the department to evaluate the impact that substitute care has made on their family. This joint evaluation should result in a decision to either continue providing foster care, emergency shelter care or group care or a decision that the family will not continue with the department.

(4) Responsibilities of the Substitute Care Parents to the Department.

(a) The substitute care parents are required to participate in 30 hours of GPS-MAPP training and at least eight hours of in-service training annually which is provided or approved by the department in order to develop and enhance their skills.

- 204

(b) The substitute care parents are required to participate with the department in relicensing studies and in ongoing monitoring of their home, and must provide sufficient information for the department to verify compliance with all rules and regulations.

(c) The substitute care parents must hold a license which is issued and monitored only by the department.

(d) The substitute parents may not accept children without the approval of the department.

(e) The substitute care parents must sign an agreement to provide foster care for dependent children for each child placed in their home.

(f) If the substitute care parent provides emergency shelter care, they must sign the civil rights compliance form. These homes are generally paid a monthly subsidy for remaining open on a 24-hour basis. The amount of the subsidy payment should be included in the agreement to provide shelter care.

(g) The substitute care parents must notify the department regarding changes which affect the life and circumstances of the shelter or foster family.

(h) The substitute care parents must notify the department at least two weeks in advance of vacations in which the child will be participating.

(i) The substitute care parents must be able to accept supervision by department staff and participate in and support case plans for children in their homes. Specifically substitute care parents must be included in the development of performance agreements or permanent placement plans, and in the carrying out of these plans.

(j) The substitute care parents must notify the department immediately of illness or accidents involving the child.

(k) The substitute care parents shall notify the department immediately, day or night, if the following situations occur:

1. A child requires hospitalization or emergency medical treatment;
2. A child dies;
3. A child has run away, is abducted, or is absent from the home beyond reasonable expectations; and

4. Any other life-threatening situation occurs.

(5) Responsibilities of the Department to the Substitute Care Parents and Children.

(a) The department or private agency will provide and coordinate training opportunities for substitute care parents.

(b) The department must share all available information on each child referred to substitute care parents since parents have to:

1. Make an informed decision about whether the child should be placed in their home; and
2. Provide appropriate care for the child.

(c) Although all information must be shared with the substitute care parents there is a core of data called the child resource

record that must be collected into a packet of information on each child, and be provided to the substitute care parents in writing at

the time of placement or within 72 hours. This packet of information for emergency shelter parents must include but is not limited

to the following:

1. Medical passport or equivalent;
2. Consent for treatment or court order;
3. Notification of hearing for dependency cases;
4. Protective Investigator health check list;
5. Dear Shelter Home Parent letter;
6. Instructions for access to health care;
7. Items to bring with child to all health care appointments;
8. Medicaid checklists;
9. List of Medicaid providers;
10. The risk assessment form;
11. Medical history;
12. Copy of Medicaid card or a current 2014 form, authorization for Florida Medicaid Eligibility, or Letter of Assurance from the department.

(d) If the child is being placed into foster care, the child resource record must be provided to the substitute family within five

days and contain the following items:

1. Medical passport;
2. Consent for treatment or court order;
3. List of Medicaid providers;
4. The risk assessment form;
5. Medical history;
6. Copy of Medicaid card or a current 2014 form or authorization for Florida Medicaid eligibility.
7. Copy of the court order or Voluntary Placement Agreement placing or accepting the child into foster care;
8. A "school information" sheet, and school records;
9. A child development recording chart;
10. An envelope for storing pictures;
11. A copy of the Service Planning Checklist;
12. A copy of the child's birth certificate. If a birth certificate is not available, one must be requested within five days of placement through the Bureau of Vital Statistics in the child's state of birth;
13. The names and phone numbers of staff to be contacted in emergencies;
14. A copy of the performance agreement or permanent placement plan if it is completed.

(e) The department must involve the substitute care parents, as team members, in all major decisions for children in their care.

(f) The department must provide substitute care parents notice of judicial and administrative review conferences regarding children in their care, and must encourage their attendance and participation in these reviews.

- (g) The counselor will visit with the substitute care parents and the children in their care at least monthly in their home.
- (h) The department must involve the substitute care parents in the development of the performance agreement, or permanent placement plan, and the visitation contract and will provide the parents with a copy.
- (i) The department must give a minimum of two weeks notice prior to moving a child except in emergency situations or upon an order by the court.
- (j) The department's protective investigation staff, accompanied by a foster care counselor, must immediately investigate abuse or neglect complaints against a substitute care parent, and will notify the state attorney's office, in accord with Section 415.505(2), F.S. This policy and procedure must be discussed with all substitute care parents prior to licensing and again at every relicensing.
- (k) The department must provide the substitute care parents a court order which authorizes the department to obtain emergency medical treatment prior to giving approval for a child to travel outside the county with the parent for an extended period of time.
- (l) The department will provide substitute care parents with an emergency medicaid card when necessary.
- (m) The department will be responsible for securing and paying for medical and dental care for children who are not eligible for Medicaid, or who need services not covered by that program.
- (n) Within 30 days of placement in family foster care, the department will coordinate with the foster care parents in making an appointment for initial Early, Periodic Screening, Diagnosis and Treatment Services and for ongoing periodic screenings. When a child is placed in shelter, the screening must be scheduled within two days of entering shelter. The department will make appointments for follow-up treatment if the need for this is identified during screening.
- (o) The department will provide substitute care parents with identification cards at the time of licensing and relicensing.
- (p) The department shall provide substitute care parents with the names and phone numbers of persons who should be contacted in emergencies.
- (q) The counselor will provide consistent feedback to the substitute care parents on their work with the child in their care.
- (r) The counselor will provide ongoing information on progress with the performance agreement or permanent placement plan for the child and the birth family, and will inform the substitute care parents immediately of any changes in the agreement or plan.
- (s) The counselor will review the child's performance agreement or permanent placement plan with the substitute care parents at least quarterly, or more often as needed.

Specific Authority 409.175 FS. Law Implemented 409.175 FS. History--New 5-27-92, Formerly 10M-6.024, Amended 11-30-97.

65C-13.011 Minimum Standards for Licensure of Family Foster Homes, Family Emergency Shelter Homes and Family Group Homes.

Section 409.175(11)(a)2., F.S., makes it unlawful for any person to make a willful or intentional misstatement on any license application or other document required to be filed in connection with an application for a license. Such a violation is a misdemeanor of the first degree, punishable as provided in Section 775.082 or 775.083, F.S. Applicants who make such willful or intentional

misstatements will have their license denied or revoked. The department has applied the recommended standards of the American Public Welfare Association when establishing the following standards. Any exceptions to the following standards must be for good cause and must be approved in writing by the district Children and Families Program Office prior to the exceptions being implemented.

(1) Family Composition.

(a) It is most desirable for the substitute care family to include two parents in order to maximize opportunities for the care and nurturing of children. This is especially true for families that provide emergency shelter care. Emergency shelter care providers are required to be available to receive children 24 hours a day. A single person may only be licensed if they have a relief person who can assist with the children. The relief person must be approved by the department and meet the screening requirements of Chapter 85-54, Laws of Florida.

(b) In instances when a child is well-established in a two-parent family foster family and the parents' marriage dissolves, the child may remain in the single parent home if his needs can continue to be met by the remaining parent.

(c) Single parent families may be selected when they can effectively meet the particular needs of a child.

(2) Number of Children in a Family.

(a) Limitations in regard to the number and ages of children to be served in a substitute care family are based on observations of the stamina, capacities, and skills of the substitute care parents, the physical accommodations, and the effect of the number and ages of the children upon the equilibrium and interrelationships of family members. However, there should be no more than two infants, under two years old, in a substitute care family, including the family's birth children.

- 206

(b) Generally there should be no more than five children in a home, including the substitute care parents' own children. This criteria may be varied for good cause and with the written approval of the Family Safety and Preservation program office. If a family has the emotional and physical capacity to nurture more than five children, it is not against policy to establish a capacity

above the rule of five. A family must have the physical room and emotional capacity to provide this care.

(c) A family substitute home may be utilized by more than one program office, provided that such joint utilization is agreed upon by the substitute care parents and the program offices involved, and that the needs of all the children placed in such jointly used family home can best be met through such placement. However, the maximum capacity of the home must be limited to the

standard for the more restrictive of the two programs and should not exceed five in most cases.

(d) A family cannot hold dual licensure to provide day care and residential care to children simultaneously.

(3) Age. The age of substitute care parents must be considered in relation to psychological maturity, health, physical energy, flexibility, ability to care for a specific child and probable duration of placement of a specific child.

(4) Income. Substitute care parents must have sufficient income to assure their stability and the security of their own family without relying on board payments. The substitute family must have sufficient income to absorb four to six weeks of a foster child's care until a board payment is received.

(5) Employment. It is preferable that one of the substitute care parents not be employed outside of the home if they provide

emergency shelter care or care for children under school age. Exceptions may be granted for emergency shelter care parents if the work schedule allows for one parent to be in the home while the other parent is at work. An exemption may also be granted in order not to split sibling groups or preclude a placement.

(6) Day Care. If both parents are employed outside of the home, the department will not rule them out from providing

substitute care. Day care for the department's children must be with a licensed day care provider. Families who wish to use a family day care provider but live in a county that does not license family day care providers must have an abuse registry and criminal records check on the day care candidates. These clearances are the responsibility of the licensing staff. Cost of day care must be assumed by the substitute care parents. The department has published a pamphlet entitled "How to Choose Quality Day Care,"

HRS/PI 175-21. Licensing staff must share this document with any substitute parent using or considering the use of child day care.

Children placed in foster care or emergency shelter care are eligible for placement in Title XX day care on a priority basis at no cost

to the substitute care provider if a determination of eligibility is made by the contract provider who handles subsidized day care.

Staff are encouraged to explore this resource to determine if a child is eligible on a case-by-case basis.

(7) Health History. Applicants are required to share health history on each member of the household including physical, mental health and other treatments received which may impair their ability to care for children. If there is a question regarding the physical, mental or emotional health of any member of the household and possible injurious effects on a child, the applicant, upon the department's request, must supply clinical reports and evaluations.

(8) Religion. A substitute care parent must be willing to provide the opportunity for a child's participation in the faith of his

choice or that requested by the birth family. A parent whose religious preference or other connections preclude the use of a licensed medical physician for the department's children may not be licensed.

(9) Screening. Substitute care parents must meet the screening requirements as stated in paragraph 65C-13.009(6)(b), F.A.C., of this chapter.

(10) Physical Facilities.

(a) The home must have access to schools, churches, medical care, recreation and community facilities.

(b) Because of the need for frequent parent child visits, the home must be located within reasonable proximity of the direct service unit providing foster care services.

(11) Physical Environment.

(a) The home must be comparable to other homes in the neighborhood in which it is located.

(b) The home and premises must be free from objects, materials, and conditions which constitute a danger to children.

(c) The home must be inspected and approved by a representative of the local health program office prior to licensing and annually thereafter. Inspections cover sanitation, health, fire prevention and safety.

(12) Play Area and Equipment.

(a) The home must have a safe outdoor play area as part of the property or within reasonable walking distance.

(b) Children who are placed in family foster homes or emergency shelter family homes that have swimming pools should be taught how to swim and be instructed in water safety as appropriate to their age.

(c) Swimming pools must have a barrier on all four sides of at least four feet. The barrier may consist of a house plus a fence on the remaining three sides or a four-sided fence. All access through the barrier must have one of the following safety features: alarm, key lock, self-locking doors or a bolt lock that is not accessible to children. When the swimming pool is not in use, all entry points must be locked. Above ground pools must have steps or ladders leading to it secured, locked, or removed when the pool is not in use. Hot tubs and spas shall be required to have a safety cover that is locked when not in use.

(d) Swimming pools must be equipped with one of the following life saving devices;

1. Ring buoy;
2. Rescue tube; or
3. Other appropriate flotation device with a rope attached which is sufficient length to cover the area.

(e) When children are using the pool or participating in water activities, the following standards will apply:
- 207

1. Children who are not proficient in swimming shall not be allowed in the pool or pool area without wearing a life jacket or approved floating device, unless engaged in swimming lessons;
2. Direct adult supervision shall be required when children are using the swimming pool, spa or hot tub, or are in the pool area.

(f) All high risk recreation, boating, water sports, or contact sports shall have direct adult supervision.

(g) As a prerequisite to licensure, foster and emergency shelter parents who have swimming pools will be required to complete a basic water safety course administered by the American Red Cross, YMCA or other national organization.

(13) Interior Environment.

(a) The home must have sufficient space, be comfortably furnished, and be accessible to all members of the family.

(b) Each child must be provided with adequate storage space for personal belongings and a designated space for hanging clothes in or near the bedroom occupied by the child.

(c) A substitute care parent should allow children to participate in decorating their bedrooms so that the area reflects their personal tastes and expressions.

(d) Each child must have his own bed and each infant his own crib. In order to ensure desirable privacy, children in substitute care must not share a bedroom with any adult, except for infants 12 months or younger. Any child over three years of age must not share a bedroom with a child of the opposite sex. Although this standard does not necessarily apply to children reared in their own homes, it is an essential safeguard for children because the nature of their early experiences may affect the development of their sexual attitudes and subsequent behavior.

(e) Usually it is not acceptable for children of any age to sleep on a living room sofa or a fold-away bed. It can be tried in

exceptional situations when it is temporarily necessary and can be managed without damage to the child. However, the substitute

care parent and the counselor will evaluate the effects on the child at frequent intervals.

(f) The following sleeping arrangements are not permitted:

1. Children sharing a bed with an adult.
2. Children of different sexes over the age three sleeping in the same room.
3. Children sharing a bedroom with an adult, except for children 12 months old and under.

(g) The home must be clean and free of hazards to the health and physical well-being of the family.

(h) The home must have a continuous supply of clean drinking water approved by the local health program office. If the water

is not from a standard city water supply, the substitute care parents must have the water tested and approved.

(i) The home must have an adequate supply of hot water for bathing and dish washing. Hot water accessible to children must not exceed 120 degrees Fahrenheit, 43 degrees Celsius, at the outlet.

(14) Foster Home Safety.

(a) All medications, poisonous chemicals, and cleaning materials must be in a locked place and inaccessible to children.

(b) Alcoholic beverages should be stored out of the reach of small children. To avoid access to alcoholic beverages by older children, it is recommended that these beverages be kept in a locked place.

(c) If the substitute care parents own a gun, the ammunition and unloaded firearm must be kept separately in locked cabinets.

(d) Pets in the foster home must be vaccinated and their vaccinations must be current.

(e) The substitute care parents must have a method to restrict children's access to large pets or potentially dangerous animals.

(f) Transportation and access to a telephone must be immediately available for use in emergencies.

(15) Fire Safety.

(a) The home must be safe from fire hazards. All combustible items must be stored away from sources of heat.

(b) The home must not be heated by unvented gas heaters.

(c) The substitute care parents must have an evacuation plan posted in a conspicuous place and must share it with each child.

The substitute care parents must conduct periodic fire drills to make sure all the children understand the procedures. Fire drills should be held at least every six months. The date of the fire drill should be recorded and reviewed at the time of relicensure.

(d) All fireplaces, space heaters, steam radiators, and hot surfaces must be shielded against accidental contact.

(e) Bedrooms in basement and above the second floor must have either a window or door with approved means of exit.

(f) The home should be equipped with the following:

1. Operating smoke alarm in each sleeping area;
2. Operating heat detection alarm in the area of the furnace or main heating source; and
3. Portable chemical fire extinguisher in the kitchen size 2A10BC.
4. If the home is equipped with burglar bars, the caregiver must demonstrate that:
 - a. The burglar bars can be released to allow exit; or
 - b. That other means of exit are readily available from each sleeping area.

(g) The approval of mobile homes is dependent upon the regulations of the local health program office.

(16) Transportation Safety.

(a) Substitute parents must have transportation available 24 hours a day. All vehicles used to transport children must be in safe condition, in compliance with applicable motor vehicle laws of the state, and equipped with seat belts and approved car seats for children under the age of four years.

(b) The substitute care parents must have all vehicles owned by them insured to include liability for transporting children.

Insurance policies should be available for inspection by the department at the time of licensure and relicensure.

- 208

(c) If the substitute parents drive they must have a valid drivers license. The substitute care parents must allow foster children

to be transported only by persons possessing a valid drivers license.

(d) The substitute parent must not transport foster children in vehicles such as truck beds, motorcycles, or any other method of transportation which would be dangerous to the child.

(17) Medical Care. Substitute care parents must be able to understand and willing to carry out home medical care prescribed by a licensed physician. Medication should not be given without first consulting the physician. Families whose religious convictions preclude the use of licensed physicians on behalf of foster children cannot be used for the care of children in the care of the department.

Specific Authority 409.175 FS. Law Implemented 409.175 FS. History–New 5-27-92, Formerly 10M-6.025, Amended 11-30-97.

65C-13.012 Substitute Family Records.

A record must be maintained for each substitute care home. Except for confidential information on abuse or neglect reports the

substitute care home record is a public record and can be reviewed by the substitute parent. Records are filed in a central place

alphabetically under three headings: Pending in the study process, Approved, and Closed. A unit file must also be established for all

approved substitute care homes which must contain all of the items listed below, and any other information which the unit may find

helpful in utilizing the home:

- (1) Application for a License;
- (2) Affidavit of Civil Rights Compliance, if appropriate;
- (3) Register of Children in Emergency Shelter Family Home, if appropriate;
- (4) Certificate of Completion;
- (5) Closing of Foster Home for Dependent Children Form;
- (6) Certificate of License;
- (7) Relicensing Summary for Foster Homes for Dependent Children;
- (8) Staff Inquiry – Annual Relicensing Study;
- (9) Telephone Inquiry;
- (10) Personal References;
- (11) Substitute Care School References;
- (12) EPSDT Agreement;
- (13) Agency Reference Sample Letter;
- (14) Confidentiality Statement;
- (15) Consent to Law Enforcement and Abuse Registry Record Check;
- (16) Affidavit for Good Moral Character;
- (17) Delinquency Checks, if appropriate;
- (18) Health Certificate Sample Letter, if appropriate;
- (19) Participant Evaluation;
- (20) Agreement to Provide Substitute Care for Dependent Children;
- (21) Identification Cards for Substitute Care Parents;
- (22) Control Cards;
- (23) Certificate of License Sample;
- (24) Substitute Care Home Ledger;
- (25) Family Profile which is signed, dated and notarized.
- (26) All GPS-MAPP materials from the pre-service training including home visits and neighbors information.

(27) Incident Reports. Client Risk Prevention reports which pertain to proposed confirmed or confirmed abuse, neglect or abandonment are confidential. These reports must be placed in an envelope or file marked confidential and should not be considered as part of the public licensing record. These records must be kept separate from the licensing file.

Specific Authority 409.175 FS. Law Implemented 409.175 FS. History–New 5-27-92, Formerly 10M-6.028.

PART II POLICIES AND PROCEDURES FOR SUBSTITUTE CARE

65C-13.013 Definitions and Glossary.

- (1) Definitions

- (a) "AIDS" means Acquired Immunodeficiency Syndrome. It involves opportunistic infections characterized by HIV positivity plus cancers which do not usually cause disease in an individual with a healthy immune system.
- (b) "AIDS Related Complex" (ARC) means a secondary level of HIV infections and requires certain criteria for a clinical diagnosis. Individuals must have two or more symptoms associated with HIV infection and two or more laboratory findings. Signs and symptoms may include loss of appetite, weight loss, fever, night sweats, skin rashes, diarrhea, tiredness, lack of resistance to infection, swollen lymph nodes, or oral thrush.
- (c) "Child" means any unmarried person under the age of 18.
- 209
- (d) "Child Health Passport" means a health history including immunizations records of children in shelter status or foster care which is used to document ongoing health care. The passport is to be kept with the child's caregiver in the Child's Resource Record (CRR) and updated at each health care provider visit. The passport should accompany the child to every placement whether it be a shelter home, foster home, licensed facility or adoptive home.
- (e) "Child-on-child sexual assault, seduction or exploitation" means sexual behavior that results in criminal charges being filed against an alleged child perpetrator, or clear and convincing evidence that leads the district to conclude that the assault, seduction or exploitation took place.
- (f) "Child's Resource Record" (CRR) means a standardized record which contains the basic legal, demographic and known medical information pertaining to a specific child. This folder is to be housed with the child and shall accompany the child to every health care encounter so that medical information may be shared with the provider and updated as appropriate.
- (g) "Child support" means support for a child placed in the custody of someone other than the custodial parent pursuant to Section 39.41, F.S.
- (h) "Client Information System" (CIS) means an automated department-wide information system which supports the planning, budgeting, management, administration and delivery of Department of Children and Family Services services. It is the primary information system for Family Safety and Preservation staff.
- (i) "Department" means the Department of Children and Family Services unless otherwise specified.
- (j) "Dependent child" means a child who has been adjudicated dependent in court proceedings.
- (k) "Dispute resolution" means the process in which interpersonal issues, concerns and conflicts which cannot be resolved between the Family Safety and Preservation counselor and the foster parent are brought to the attention of administrators who will mediate or otherwise resolve the dispute at the district level. Resolution of the dispute does not include the right to a Chapter 120, F.S., hearing. Nor shall the services received by a foster child be subject to dispute resolution process. Such issues are within the exclusive jurisdiction of the court with jurisdiction over the child's dependency case, pursuant to Chapter 39, F.S.
- (l) "Early Periodic Screening, Diagnosis, and Treatment" (EPSDT) means comprehensive preventive health screening and corrective treatments for all Medicaid eligible youth under the age of 21. The screening includes health and developmental history, physical assessment, updating of routine immunizations, laboratory tests, developmental assessment, vision, hearing, and dental

screening and health education.

(m) "Family foster home" means a licensed private residence providing 24-hour care for children who are unattended by a parent or legal guardian. Such homes include emergency shelter family homes, foster family group homes, and specialized foster homes for children with special needs. Excluded are persons who care for an unrelated child for a period not to exceed 90 days, relatives who care for a child and do not receive board reimbursement from the state or federal government and adoptive parents who have been approved by the department or by a licensed child-placing agency for children placed for adoption.

(n) "Family Support Plan" (FSP), previously termed Individual and Family Service Plan (IFSP), means a written document prepared cooperatively by appropriate individuals and the child/family which specifies the services required, outlines accountability for arranging and delivering services, and outlines accountability for financing services.

(o) "Guardian" means an adult who has been awarded legal guardianship of a child.

(p) "Guardian ad Latin" (GAL) means a responsible adult who is appointed by the court to represent the best interests of the child in a proceeding as provided for by law, who shall be a party to any judicial proceeding as a representative of the child, and who shall serve until discharged by the court.

(q) "HIV" means Human Immunodeficiency Virus or HTLV-III/LAV identified as the causative agent of Acquired Immunodeficiency Syndrome.

(r) "Informed consent" means consent evidenced by the valid signature of the parent or legal guardian who is mentally capable to give consent for a specified non-routine procedure. The benefits and risks of the procedure must have been presented. The person signing must have the opportunity to ask questions, have them answered, and remain in agreement that the procedure may be performed. This consent may be withdrawn at any time either in writing or verbally.

(s) "Lead case manager" means the individual employed by the department who accepts primary responsibility for assuring that all services specified in the Family Support Plan (FSP) have been appropriately arranged and delivered. This individual becomes the central focal point for all information relative to the case in question. At the Multiple Handicap Assessment Team (MHAT) staffing the lead case manager will be identified or reconfirmed by the staffing participants for each pediatric client under consideration for placement.

(t) "Medicaid" means a governmental health care program that provides to eligible needy persons assistance in meeting the cost of medical care. For more details concerning the Medicaid program, consult Chapter 59G-4, F.A.C.

(u) "Medically complex" means a chronic debilitating disease or condition that involves one or more physiological organ system which generally make the individual dependent upon 24-hour a day continual medical/nursing/health supervision or intervention. It includes individuals 0-21 years of age.

(v) "Medical home" means a health care site used by an individual to obtain routine and required health care treatment, consultation, and referral.

(w) "Multiple Handicap Assessment Team", MHAT, means a Department of Children and Family Services district team of professionals consisting of the following:

1. A board certified pediatrician with experience in the interdisciplinary assessment and planning for infants, children, adolescents and young adults with complex medical problems who shall serve as its director and be referred to as the Multiple Handicap Specialist, MHS.
 2. A registered nurse who meets the requirements for the CMS registered nurse specialist position.
 3. A clinical social worker with experience in the interdisciplinary assessment and planning for infants, children, adolescents and young adults with complex medical problems.
 4. A representative from the district Medicaid Program Office.
 5. A representative from the district Developmental Services Program Office.
 6. Other professionals who may be added to the team based on the needs of the child/family.
- (x) "Ordinary medical care and treatment" means necessary medical and dental examination and treatment including blood testing, preventive care, tuberculin testing, and well-child care; this does not include surgery, general anesthesia, provision of psychotropic medications, or other extraordinary procedures for which a separate court order or informed consent is required.
- (y) "Parent" means the natural or adoptive father or mother or the legal father of a child. "Parent" also includes a legal guardian or an adult custodian or relative of a child with whom the child lives at the inception of a protective investigation or to whom the child will be returned once it has been determined that the level of risk has been reduced to an acceptable level. "Parent" does not include a relative or non-relative with whom a child has been placed by the department for the child's protection during a protective investigation or while the child is receiving protective supervision.
- (z) "Pseudo-I.D." means a nine digit identification number comprised of the client's initials and date of birth to be utilized when the social security number is unknown or has not been issued.
- (aa) "Referral" means identifying and providing linkage to the specific services needed by each parent in order for them to substantially comply with his or her performance agreement.
- (bb) "Relative" means, in addition to parent, any blood relative, including those of half-blood, first cousins, nephews, nieces and persons of preceding generations as denoted by prefixes of grand, great or great-great. This group includes the sister, brother, aunt and uncle of the child. Stepfather, stepmother, stepbrother and stepsister are relatives. Also included as a relative is the person who legally adopts a child or the child's parent, as well as the natural and other legally adopted children and other relatives of the adoptive parent.
- (cc) "Service provider" means either department units or independent agencies under contract with the department who provide varied social services to clients. The definition also includes independent agencies or parties from whom the department purchases services.
- (dd) "Substitute Care" means care provided to a child in a foster family home, family group home, therapeutic foster home, or residential group facility.
- (ee) "Title IV-E" means a federal grant appropriated for the purpose of enabling each state to provide shelter, foster care and transitional independent living programs for children for whom it has been judicially determined that remaining in their own home would be contrary to their best interests and that reasonable efforts were made to prevent removal from their home. At removal, the

child's family must be AFDC eligible or potentially eligible.

(ff) "Unaccompanied minor" means a person who has not yet attained 18 years of age or has attained 18 years but is still enrolled in post secondary education, a community college or a university; who entered the United States unaccompanied by and not destined to a parent or a close non-parental adult relative who is willing and able to care for the child or to an adult with a clear and court-verified claim to custody of the minor; and who has no parent in the United States.

(2) Glossary.

(a) "ADM" means Alcohol, Drug Abuse and Mental Health.

(b) "AFDC" means Aid to Families with Dependent Children.

(c) "ARS" means Adoption and Related Services.

(d) "CPHU" means County Public Health Unit.

(e) "DA" means District Administrator.

(f) "FPSS" means Florida Protective Services System.

(g) "OPA" means Operations Program Administrator.

(h) "TPR" means Termination of Parental Rights.

Specific Authority 39.012 F.S. Law Implemented 39.001, 39.01, 39.45, 409.145, 409.165 F.S. History—New 5-20-92, Amended 7-18-95, Formerly 10M-6.125.

65C-13.014 Entry into Foster Care.

(1) Involuntary Placement.

(a) A child may be removed from his/her home by order of the court due to abandonment, abuse or neglect by the parent or

other caretaker; however, when the child or the child's family falls within the statutory provisions of families in need of services

(FINS) and children in need of services (CINS), that circumstance in and of itself is not sufficient grounds for the department to

recommend removal of the child. Placement of a child in foster care can be considered only if the child is in immediate danger and

protective custody is necessary, and one or more of the following conditions have occurred:

- 211

1. The child has been physically, emotionally or sexually abused or neglected by the parent, guardian, or other custodian.

2. The parent is experiencing excessive social, economic or psychological stresses or has demonstrated insufficient maturity

for parenting.

3. The whereabouts of the parent are unknown and there is no appropriate relative to provide care.

4. The parent-child relationship is in severe conflict, and the parent has abdicated responsibilities for the child's care.

Placement in foster care must not be considered a desirable alternative for children who are ungovernable or truant.

Ungovernability can be most effectively dealt with in the family since it usually centers around interpersonal relationships within

the family system. Services through FINS and CINS are available through the delinquency case manager to assist the family and

the ungovernable child. If a child has run away due to abuse or neglect and removal from the home is required, it is appropriate to

consider a foster care placement as an alternative.

5. It has been determined that the problems in the child's home are seriously detrimental to the child's safety and well-being,

and protection of the child cannot be assured through the provision of in-home services.

(b) The parents, legal guardians or other custodians of children placed involuntarily in foster care shall not remove the children

from foster care without the written consent of the court.

(2) Voluntary Placement.

(a) A parent may request the assistance of the department in planning for the temporary care and supervision of a child. A relative, as defined in Rule 65C-13.102, F.A.C., may also request such assistance if the child lives with the relative and neither parent resides in the home. The department will conduct a thorough assessment of the situation. The assessment shall clearly identify the family's problems, shall determine whether the family's problems are temporary in nature, and shall provide a basis upon which a mutual decision regarding the child's short-term placement out of the home can be made. The department shall begin immediately to identify available social, health, mental health, educational, and other support services within the community which would enable the parent, guardian or relative to more adequately provide for the child's care. The department shall help the family to use and coordinate available services effectively, prior to considering placement of the child in foster care.

(b) If a child's medical complexity is such that the parent is unable to provide the necessary care for the child, and it has been determined that the child would benefit from placement outside the home, the parent may apply for voluntary placement in medical foster care. Voluntary placement is contingent upon:

1. The child meeting the level of care criteria as determined by the District Multiple Handicap Assessment Team (MHAT) placement being recommended by the MHAT.
2. Vacancies in existing medical foster homes and the capacity of an available home to meet the needs of the child as determined by the medical foster care program.

(c) A child shall not be accepted for voluntary placement unless current circumstances clearly indicate a foster care placement of three months or less is anticipated, and no dependency issue exists.

(d) In the absence of information demonstrating the need for the child's protection, the department shall immediately honor requests for voluntary return of the child to the parent or other custodian. The department shall not file a petition and request a detention hearing unless information is found which indicates dependency, and the child is in need of protection.

(e) When the child is placed into foster care voluntarily, the parent and the department shall enter into a written voluntary placement agreement which at a minimum shall specify the following:

1. Legal status of the child;
2. The child's date of birth;
3. The rights, obligations and responsibilities of the parent, relatives, guardian, child, and the department while the child is in placement;
4. The conditions under which the agreement would be breached, appealed, modified, or terminated; and
5. The parent's right to revoke the agreement and to request that the child be returned home or be placed in the home of a relative, as described in paragraph 65C-13.014(2)(b), F.A.C.

(f) A child voluntarily placed with the department may not remain in foster care on a voluntary basis beyond three months unless the district Family Safety and Preservation program administrator or designee has determined that the specific situation of a child or family necessitates continued placement beyond three months and has given written authorization for continuance. If reunification has not occurred within 180 days and it is determined that an adjudication of dependency is not warranted, and the

specific situation of the child or family necessitates continued placement beyond 180 days, the district Family Safety and Preservation program administrator or designee may authorize recommendation to the court for continued voluntary placement.

The foster care specialist will monitor such extended voluntary placements to ensure they do not linger unnecessarily.

(g) If a child placed voluntarily remains in care, a judicial hearing must take place within the first 180 days, and the resulting

court order must declare that the continued placement is in the child's best interest and that reasonable efforts have been made to reunify the family.

(h) If the court extends the voluntary placement status, the child shall receive subsequent judicial review hearings according to

the same schedule as any child who remains in care pursuant to Section 39.453, F.S.

- 212

(i) When parents request that their child be returned to them for a voluntary foster care placement, the child must be released

unless the department seeks relief from the court. If the department opposes or otherwise objects to the release of the child or

reunification of the family, a judicial determination at a shelter detention hearing held pursuant to Chapter 39, F.S., must be

obtained.

(3) Prior to foster care placement a planning conference must occur.

(a) The conference is held at the point in a protective investigation or in a protective services or post-placement supervision

case when the child has been removed from his/her in-home placement, placed on shelter status, and when no other in-home

placement is considered appropriate. For voluntary placements the planning conference must be held at the point when the

placement is considered or has already taken place due to an emergency situation.

(b) The purpose of the planning conference is:

1. To provide an opportunity for all parties to share in decision-making in regard to the need for foster care placement and to

facilitate the exchange of information required for coordinating service delivery to the child and family; and

2. To initiate early service intervention so that services to the child and family can begin while the child is in shelter status, and

to continue disposition.

(c) The tasks of the planning conference are as follows:

1. To ensure that the expertise of all involved professionals is utilized in planning for children and families;

2. To ensure that all assessment information, including a complete risk assessment instrument, is completed so that necessary

information is available for responsible decision-making;

3. To identify the parental behavior or conditions resulting in the child's need for placement and to consider the counselor's

assessment of actual or potential harm to the child;

4. To ensure that all available services designed to prevent placement have been or will be provided. If no preplacement

services were provided, establish that either the particular services are not available in the community, or that they are not sufficient

to ensure protection of the child;

5. To ensure that funds appropriated for placement of dependent children are considered to help prevent placement if such

expenditures are an eventual cost savings over placement pursuant to Section 409.165(1), F.S. The following apply to use of these

funds:

- a. Dependent or potentially dependent children who are at imminent risk of placement who can be safely served in their own homes or those of relatives are eligible for these funds.
- b. There must be a clear connection between the service or product delivered to meet the needs of the child and the prevention of the need to place the child.
- c. The proposed intervention must be time-limited; for example, the placement funds can be used to purchase transportation during the reasonable amount of time it takes to clear the waiting list for community transportation services.
- d. Placement funds must be used for necessities rather than what is merely desirable.
- e. Commodities and provisions are justified when the child or family is not eligible for, or is on a waiting list to receive services from another source such as AFDC, Medicaid, Housing and Urban Development (HUD) or other community agency.
- f. The Family Safety and Preservation counselor must report funds granted to relatives and parents who are receiving AFDC or food stamps to the local AFDC or food stamp office so that public assistance staff may determine how this income may affect eligibility;
- 6. To review the possible impact which placement may have on the particular child under consideration. This review includes assessment of parent-child attachment, previous placement history, and the child's sense of time based on age;
- 7. To review information which individualizes the child to ensure that a proper selection of the foster care provider is made; to identify specific placements that are available; and if the child is part of a sibling group, to determine if and how the siblings should be placed together;
- 8. To ensure that relative placement resources have been or will be explored;
- 9. To identify and clarify the specific responsibilities of the referring counselor and foster care counselor;
- 10. To develop an initial case plan which identifies goals, needs, and services to be provided prior to court disposition.

(4) For both voluntary and involuntary placements, the department shall coordinate its efforts with other agencies, particularly local school districts and community alcohol, drug abuse and mental health agencies to acquire services. *Specific Authority 39.012 FS. Law Implemented 39.001, 39.41, 39.45, 39.46, 409.145, 409.165 FS. History—New 5-20-92, Formerly 10M-6.126.*

65C-13.015 The Prevention and Management of Sexual Assault in Foster Care.

- (1) Prior to a foster care placement the needs and risk factors of the foster child must be considered in selecting the placement. A complete background check is required. This would alert professionals and caretakers to the necessary precautions to take concerning a vulnerable child or one prone to victimizing other children.
- (2) The following safeguards are to be used by the department on a routine basis:
 - (a) Caregivers must be given detailed and complete information so they can understand the circumstances of the maltreatment in order to avoid an unwilling replication of those circumstances.
 - (b) If possible, ensure that the child who sexually abuses or victimizes other children is the youngest one placed in the home. Consideration should also be given to other vulnerabilities of the children, e.g., mental handicap, physical handicap, chronic illness, and physical size.
 - (c) Within 10 working days of an incident of sexual assault, seduction or exploitation, the perpetrator and the victim must be

referred for assessment by a mental health provider to determine the need for therapy. If either one is currently receiving therapy, the details of the incident must be discussed with the therapist.

(d) Ensure that the provider has access during night and weekend hours to a counselor, if assistance is required.

(e) Staff and caregiver together must outline a plan of care to handle any special management issues identified in the child's

history and assessment. It is important that the plan be preventive in nature. The following must be taken into consideration:

1. Placing the child in a private bedroom;
2. Limiting access to the child's bedroom;
3. Establishing rules regarding bathroom utilization;
4. Establishing a dress code; and
5. Establishing reasonable guidelines concerning the manner and extent of the expression of affection between the child and others, as well as which persons may be left alone together, and under what circumstances.

(3) When child-on-child sexual assault, seduction or exploitation occurs in a foster home, shelter home or residential facility,

usually one of the following is a factor:

(a) There is a significant difference in the age or size of the children involved; or

(b) Force or threats are used by the alleged perpetrator.

(4) The following reporting procedures are required when a child-on-child sexual assault, seduction or exploitation incident is

alleged:

(a) Whoever first becomes aware of the situation is required to report the information to the FPSS Abuse Registry if is

suspected that the alleged victim lacks supervision or has been neglected or abused by the caretaker.

(b) If no report is taken by the abuse registry, all information pertinent to the child-on-child sexual incident will be transmitted

to the OPA for protective investigations in the appropriate county as a request for services.

(c) The OPA for protective investigations will share all information with their counterpart OPA for foster care to ensure that a

service worker will visit the home or facility, assess the situation and provide the follow-up services needed.

(d) In situations where there is no suspected lack of supervision, or other neglect or abuse, all pertinent information about the

home or facility, subjects of the report and the situation will be relayed to the OPA for foster care. If there is cause to suspect

neglect or abuse on the part of the caregiver, the incident must be reported. It then becomes the responsibility of protective

investigation staff to screen for neglect and abuse and make that determination.

(e) In either case, whether the report is made to the abuse registry or directly to the OPA for foster care, the counselor is to use

the Comprehensive Client Risk Management form to report the client-on-client sexual assault, seduction or exploitation. The

counselor will also report the alleged offense to local law enforcement and notify the parents of the alleged victim.

(5) Once an incident of sexual assault, seduction, or exploitation has been reported and confirmed, follow-up procedures are:

(a) The OPA responsible for the licensed caregiver and the OPA with responsibility for the program serving the child, if

different, will determine who will take lead responsibility and how the matter will be handled. Issues to be addressed include:

1. Licensing;
2. Initiating safeguards;
3. Removal of children; and

4. Follow-up mental health assessment for victim and victimizer.

(b) The appropriate OPA for foster care will ensure that the safeguards listed in subsection 65C-13.109(2), F.A.C., are implemented.

Specific Authority 39.012 FS. Law Implemented 39.001, 39.01, 39.41, 39.45, 39.46, 409.145, 409.165 FS. History—New 5-20-92, Formerly 10M-6.132.

65C-13.016 Health Care.

(1) A health care plan shall be developed in each district to ensure that initial and on-going health services are provided to

foster children. The plan includes information specific to:

(a) Procedures for Family Safety and Preservation staff to interface with the Florida On Line Recipient Integrated Data Access

(FLORIDA) system to obtain Medicaid eligibility and coverage for eligible children;

(b) Procedures for determining other known providers through the CIS, and contacting them to share information;

(c) Procedures to ensure that each child is screened by a licensed health care professional using EPSDT procedures or an examination that meets the same criteria as EPSDT within 72 hours after placement in shelter status. Once the child is screened:

1. Medical, dental or mental health needs identified during the EPSDT screening or comprehensive office visit will be met through Medicaid services, to the extent that services are covered and providers are available.

- 214

2. Expanded Medicaid services through the Omnibus Budget Reconciliation Act of 1989 provide most medical services for

foster children. Many expanded services will be provided based on medical necessity and require authorization by the district Medicaid Service Authorization Nurse.

3. Project AIDS Care provides home and community based services necessary to eligible children who have AIDS/ARC. See subsection 65C-13.017(6), F.A.C., for details;

(d) The mechanism to ensure that transportation for medical purposes is available 24 hours a day, seven days a week and that

Department of Children and Family Services Medicaid transportation is used whenever possible;

(e) Procedures to ensure that the foster child has an appropriate escort for health care appointments as necessary;

(f) A system by which shelter or foster parents are to be informed of any services which are available such as Children's

Medical Services, CMS, and Alcohol, Drug Abuse and Mental Health, ADM, and Medicaid providers;

(g) Procedures for staff to access services of the Child Protection Team, CPT, including consultative services;

(h) The method of determining that every child entering shelter care has a known medical home which will be the local

Department of Children and Family Services County Public Health Unit, CPHU, if the child does not already have one;

(i) A system to notify all health care providers of the new caregiver's name, address and telephone number within 72 hours of

a child's move to a new location; and

(j) Procedures directing the content completion, location and maintenance of the Child's Resource Record (CRR) and ensuring

the shelter/foster parent has the CRR.

1. The CRR shall contain:

a. The child's health passport;

b. Consent for treatment or court order;

c. Notification of hearing for dependency cases;

- d. Health checklist;
 - e. Shelter home parent letter;
 - f. Instructions for access to health care;
 - g. List of items to bring with child to all health care appointments;
 - h. Medicaid checklist;
 - i. List of Medicaid providers;
 - j. Medical history; and a
 - k. Letter of assurance or Medicaid card.
2. The foster care counselor will review all information in the CRR with the foster parents when the child is placed with them.
 3. The foster care counselor shall ensure that the foster parent understands the importance of the CRR and that it must accompany the child on all health care provider visits and must accompany the child on any subsequent placement.
 4. The foster parent will be instructed by a health care provider on the use of any medical equipment, device of medication accompanying the child prior to implementing its use.
 5. The CRR shall be reviewed quarterly, initialed and dated by the foster care counselor. This review shall ensure that all appointments prescribed by the health care provider have been kept, health care has been rendered as prescribed, and the information is current, legible and accurate.
- (2) A health training package shall be available for shelter or foster parents.
 - (3) The department shall at all times make a reasonable attempt to obtain the authorization of the child's parent or legal guardian for any medical, dental or psychological treatment. After a reasonable and documented attempt to contact the parent(s) is unsuccessful, then the department is authorized to consent to ordinary care as stated in Section 743.0645, F.S.
- (a) The documentation of attempts to contact parents shall include:
 1. Evidence of contacting parent or legal guardian, including content of conversation and disposition;
 2. The number of attempted telephone calls or other resources utilized;
 3. Objective information explaining inability to contact parent or legal guardian;
 4. Names of all staff who participate in efforts to locate parent or legal guardian.
 - (b) If a parent or guardian is available but refuses to consent to treatment, a court order shall be required prior to the examination or ordinary and necessary medical treatment including immunizations, unless the treatment is considered an emergency. The parent's refusal shall be documented in the child's case record. The court order authorizing routine and emergency care may be used in this situation.
 - (c) In addition to the completion of a consent for medical treatment, immunizations require that a "Vaccine Information Pamphlet/Important Information Statement" be signed by the parent or guardian prior to the immunization. If an immunization is given in three doses, the particular "Vaccine Information Pamphlet/Important Information Statement" or an immunization clinic record or signature card must be signed prior to each dose. This requirement is in no way to be considered a barrier for children to receive the required immunizations but is a safeguard that the parent or guardian be aware of the possible side effects and be prepared to handle them should they manifest.
 - (d) The department is authorized to sign the "Vaccine Information Pamphlet/Important Information Statement" or immunization clinic record/signature card following documentation of failed efforts to reach the parents.

(e) Once the current specific “Vaccine Information Pamphlet/Important Information Statement” has been signed by the parent or the counselor, when the parent is unavailable, it must be presented to the CPHU or other health care provider prior to immunization. It may be mailed, faxed or delivered by the person taking the child to receive the immunization. If faxed, the signed original must be sent to the medical provider.

(f) If someone other than the foster parent takes the child to receive an immunization, the counselor shall ensure that the foster parent is informed of the possible side effects of the upcoming immunization and how to handle these side effects if they occur.

(4) For extraordinary care such as surgery, general anesthesia, provision of psychotropic medication or other extraordinary procedures, the parent must sign informed consent. If the parent is unavailable, a separate court order must be obtained to authorize the treatment.

(5) Instructions for placements of infants and children with complex medical problems include the following:

(a) Any child who meets or appears to meet the definition of medically complex must be staffed by the Multiple Handicap

Assessment Team, MHAT. This staffing should take place prior to foster care placement or as soon as possible thereafter.

1. The Family Safety and Preservation counselor assigned to the medically complex foster child will participate as an MHAT team member.

2. The Family Safety and Preservation counselor will notify and include the child’s caregiver and parent, unless prohibited by the court.

3. A lead case manager will be identified at the initial MHAT staffing.

(b) Functions of the MHAT staffing are as follows:

1. To conduct a comprehensive assessment which includes family demographics, medical history, psychosocial history, environmental assessment, developmental history, educational status and financial assessment to include third party resources;

2. To determine the level of care needed by the child;

3. To make a placement recommendation; and

4. To develop a family support plan, FSP, that addresses all areas of the process. The lead case manager will ensure that the FSP is written within seven working days of the staffing and includes a date to review the plan.

a. The FSP will identify the person responsible for ensuring that appropriate services are obtained and the time frame within

which the services will be obtained;

b. The FSP will address needs and services in the areas of medical/health, psychosocial, environmental, educational, financial, developmental, therapeutic and family support;

c. The FSP also identifies service needs which may not be met due to a lack of resources;

d. The FSP will further address the areas for which the family or caretaker will be responsible and will specify the additional training that is required to assist the family in meeting the needs of the child;

e. The FSP will identify the parties or agencies/programs that will be financially responsible for obtaining specified services;

f. A copy of the written plan will be distributed to all members involved in the staffing;

g. The FSP will be attached to the performance agreement or permanent placement plan but will not be filed with the court.

(c) The lead case manager will maintain responsibility for tracking achievement of the activities/services listed in the FSP.

1. The first review of the FSP by staffing participants will be conducted on the date established at the initial MHAT staffing which should be no later than three months from the initial staffing.
 2. Appropriate, timely intervals for subsequent reviews will be established based upon the time frames established for delivery or follow-up services specified in the plan.
 3. The lead case manager will invite all staffing participants to review the plan and request reports from each participant in order to facilitate a written update of the plan.
 4. All revisions in the plan needed to meet the changing needs of the child and family will be made in writing within seven working days of the staffing.
 5. The lead case manager will be notified when the child is no longer eligible for a program due to changes in financial or program status and will notify other staffing participants of this change.
 6. No program involved with the child or family will close the child or family to a particular program service such as homemaker or respite care without concurrence of the MHAT.
- (d) The district Family Safety and Preservation program administrator or designee will be responsible to track the progress of infants and children with complex medical problems. Each district will have an operating procedure which includes the data to be collected. At a minimum it will include:
1. Date and outcome of MHAT staffing;
 2. Name of lead case manager;
 3. The name and date of birth;
 4. Diagnosis;
 5. HRS programs involved;
 6. Type of third party, including Medicaid;
 7. Placement of child;
 8. Annual departmental expenditures by type of service; and
 9. Date of discharge from MHAT oversight.

- 216

Specific Authority 39.012 FS. Law Implemented 39.001, 39.01, 39.41, 39.45, 39.46, 409.145, 409.165, 743.0645 FS. History—New 5-20-92, Formerly 10M-6.138.

65C-13.017 Services for HIV Infected Children.

- (1) Placement for HIV infected children requires special consideration. The following are guidelines for selection of the most appropriate placement.
- (a) Children with HIV infection, including children with AIDS, must be placed in the least restrictive placement available. Foster families are considered to be the placement of choice.
- (b) Prospective foster parents for children with AIDS should meet the following criteria:
1. A single or married adult;
 2. A family with no child under the age of 10 due to potential exposure to infections introduced by a younger child;
 3. Adults who are knowledgeable about AIDS, particularly through their occupations, have expressed confidence in handling a child with AIDS and who have little fear of transmission;
 4. Family members in good health and free of potentially infectious diseases;
 5. Families who live within reasonable traveling distance from medical providers and facilities;
- (c) Age alone should not be a barrier;
- (d) Because children with AIDS are at risk of infection from other children and because of the amount of attention normally

required by children with AIDS, they should be placed in a foster home as the only child, if under the age of 10.

(e) For children over 10 years of age, no more than two children known to have AIDS should be placed in the same foster care

setting, unless the home or facility specializes in the care of children with AIDS. A waiver to exceed this number shall be obtained,

if necessary. Whenever possible, the children should be close in age.

(f) Children known to have AIDS should not be placed in shelter because they are at risk of infection from other children. The

medical status of children in shelter status may be unknown to the department.

(g) If it is found that a child in shelter care has AIDS, the shelter parent shall be notified immediately so that necessary

precautions can be taken to ensure that the child is not exposed to anyone in the home who may be ill.

Shelter parents must be

instructed to notify the Family Safety and Preservation counselor immediately if they learn that a child has AIDS. The following

procedures must then be implemented:

1. The Family Safety and Preservation counselor will arrange for a service planning conference to develop a plan for another

placement as soon as possible.

2. The following must be notified and given an opportunity to attend the service planning conference:

a. The child's attending physician or designee;

b. The child's parent unless confidentiality provisions apply;

c. The district AIDS coordinator; and

d. The Project AIDS Care case manager, if applicable.

(h) Children who are HIV infected without symptoms of AIDS normally do not require special placement procedures, unless

the child is exhibiting high-risk behaviors. In such instances, the staffing procedure outlined in paragraph 65C-13.017(1)(f), F.A.C.,

shall be followed to determine an appropriate placement. Because the child carries the HIV virus and, therefore, is capable of

transmitting the virus, procedures for personal and environmental hygiene practices should be followed.

(i) The Family Safety and Preservation counselor shall provide the caretaker with a copy of the most current information from

the Centers for Disease Control (CDC) regarding procedures for personal and environmental hygiene practices related to HIV

infection. The counselor shall review the procedures in detail with the caretaker and answer any questions the caretaker may have.

The review must be documented in the child's case record.

(2) The number and frequency of visits with the foster families and children depend upon the professional support needed to

cope with the problems and stress created when caring for a child with serious illness. These families must be contacted weekly, by

telephone if not face to face. At a minimum, the families must be visited once a month.

(3) Foster parents shall receive a rate of payment according to the rate structure established by the department or through a

contract the department may have with a community-based provider. Although a foster family is considered the placement of

choice, it is recognized that at times, due to a child's age or presenting problems, it may be necessary to place the child in a group

home. Foster or group home parents will continue to receive payment if a child needs hospitalization.

During the child's

hospitalization, the foster or group home parent is expected to continue regular contact with the child.

(4) Children's Medical Services, CMS, and Developmental Services, DS, programs may supply such services as the purchase

of equipment, supplies, extra clothes, physical therapy, occupational therapy, gastrostomy feeding, tracheotomy care and debridement.

(5) The department will reimburse Medicaid providers for covered medical services needed by the child. If a service is not

covered by Medicaid, the department will make funds available at the Medicaid rate to provide what are determined to be necessary services by the attending physician.

(6) Medicaid is authorized to reimburse foster parents for a wide range of home and community-based services to foster children who are Medicaid eligible and diagnosed as having AIDS or AIDS Related Complex, ARC. The specialized services are referred to as Project AIDS Care.

- 217

(a) In order to receive these services, the foster care child must be eligible to be enrolled in Project AIDS Care. Eligibility

requirements are as follows:

1. The child must be determined SSI eligible or disabled.

2. After disability or SSI eligibility has been established, the child's primary physician must refer the child to the district's

Comprehensive Assessments and Reviews for Long Term Care Services, CARES, unit.

3. If the CARES unit determines that the child meets the level of care criteria, the district Project AIDS Care case management

agency will estimate the total monthly cost of services and determine eligibility for enrollment in the project.

(b) The case management agency in cooperation with the district service authorization nurse or case manager will develop a

plan of care based on the needs of the child. The plan may include services which can be billed to Medicaid.

(c) Specialized personal care services to foster care children is a Project AIDS Care service provided by foster parents for

which Medicaid reimburses at a daily rate.

(7) The following children should be considered at risk and should be tested following consent and counseling:

(a) Children born with a positive drug screen for those drugs commonly self-administered by injection. Hospital staff will

normally discover these children and request appropriate permission prior to the children's leaving the hospital following birth;

(b) Children of mothers who admit to present or past use of injection drugs;

(c) Children with symptoms of drug withdrawal and where (d) also applies;

(d) Children whose mothers have a history of arrests for drug offenses or prostitution, or a professional has observed that the

mother is using injection drugs;

(e) Any abandoned newborn;

(f) Children with clinical symptoms of acute HIV infection or AIDS as described by guidelines and criteria of the Centers for

Disease Control, CDC.

(g) Children with no clinical symptoms but who engage in high risk behavior such as:

1. Males who have had sexual intercourse with one or more males;

2. Males or females who have had multiple sexual partners;

3. Sexual partners of any of the above groups;

4. Males or females who have used injection drugs and may have practiced needle sharing or who have engaged in other needle

sharing behavior such as tattooing or ear piercing;

5. Persons with hemophilia who have received clotting factor concentrates, whole blood or blood product before March 1985;

or

6. Children who may have been exposed to infectious bodily fluids of a person known to be infected with HIV in such a way

that the virus may have been transmitted such as children who have been sexually abused; or

(h) Any child requesting to be tested for HIV infection.

(8) HIV antibody testing shall be provided under the following conditions:

(a) Informed consent of the child or the child's parent is obtained and documented in the case record.

(b) A minor may obtain consultation, examination and treatment for any sexually transmitted disease, including HIV, from an

appropriately licensed health care professional. The consent of a parent or guardian is not a prerequisite for examination or

treatment of a sexually transmitted disease.

(c) The facts of a consultation, examination and treatment of a minor for a sexually transmitted disease are confidential and

shall not be divulged in any direct or indirect manner such as sending a bill for services to the parent, except under certain

conditions as outlined in Section 384.29(1)(a)-(e), F.S.

(d) Prior to testing, the child or, where applicable, the parent shall be informed of the following:

1. The purpose of the test;

2. The meaning of the test results;

3. Methods of transmission and exposure; and

4. The voluntary nature of the test.

(e) If the child refuses or is unable to grant informed consent and shows clinical symptoms of HIV infection or AIDS or if there

is competent evidence to support a reasonable belief that the child is considered at high risk, procedures should be initiated to

obtain authority from the parents or the court to conduct the antibody tests.

(f) Once the tests are completed, the child must be provided age appropriate follow-up support and educational materials. The

child's parent or guardian should receive similar follow-up support. Culturally sensitive and language appropriate counseling

should be provided.

(9) Counseling includes group and individual counseling, emotional support groups, one-on-one emotional support, HIV

education, and information services. Sexually active gay, bisexual, and heterosexual youth must receive age appropriate

counseling, which takes into account their developmental level, regarding their sexual practices. When selecting a counseling

resource for a gay or bisexual child, special care shall be taken to ensure that the resource can meet the special and non-judgmental

information needs of that child. Children with hemophilia and other children who have received blood or blood products through

transfusions, where that is considered the source of acquisition of HIV infection, must also receive counseling geared to their

special circumstances. A third group with possible specialized counseling needs are current and former injection drug abusers.

- 218

(10) HIV and AIDS hotlines are available through Department of Children and Family Services and the Department of Health

and Human Services.

(11) Children found positive by the screening tests shall be medically evaluated to determine status of their immune systems in

order to provide appropriate referral and treatment.

(12) HIV infected children, and when applicable their parents or guardians, who have pending or future discharge plans shall

receive counseling and education to assure that, to the extent possible, they understand:

- (a) The nature of their HIV infection;
- (b) Methods of transmission of the virus and prevention of transmission;
- (c) Sound health care principles including the need for periodic medical evaluation;
- (d) Infection control guidelines; and
- (e) The need to notify sex partners or needle-sharing partners of their exposure to HIV and the availability of notification services through the Department of Children and Family Services STD program.

(13) The identity of any foster child upon whom an HIV test is performed and the HIV test result shall be disclosed only to an employee of the department or to an employee of a child-placing or child-caring agency who is directly involved in the placement, care or custody of such child and who has a need to know such information. An employee of the department has a need to know the identity of a foster child and his or her HIV test results if:

- (a) The employee is involved in case specific services such as assessing needs, determining eligibility, arranging care, monitoring care, planning permanency and meeting the legal requirements for the child in foster care; or
- (b) The employee is involved in case specific supervision or monitoring of cases for eligibility or legal compliance or quality of casework; or
- (c) The employee is involved in providing case specific clerical and vouchering support necessary for case management and legal activity; or
- (d) The employee of the CPHU is involved in providing medical care to the child.

(14) The identity of any foster child upon whom an HIV test is performed and the test result shall be disclosed only to a foster family licensed pursuant to Section 409.175, F.S., who is directly involved in the care of such child and in addition has a need to know such information. The identity of the child shall be disclosed after the following conditions are met:

- (a) The department or child-placing or child-caring agency has provided all available medical information, including HIV test results, social information and special needs, in a manner that does not permit identification of the child, and
- (b) The decision to place the child in a specific foster home has been confirmed.

(15) The foster family who has accepted an HIV infected child into their home shall be given a statement in writing which states: "This information has been disclosed to you from confidential records. The confidentiality of this record is protected by state law which prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law."

(16) The foster care record shall contain documentation that the written statement was given to the foster family.

(17) The child's guardian ad Latin, if one has been appointed, must be told of the child's test results.

(18) The child's medical practitioner, including dentist, must be told of the child's HIV infection. It is particularly essential that prior to immunizations a physician or the Department of Children and Family Services CPHU who is giving the child immunizations be informed that the child is HIV infected with symptoms or HIV infected without any symptoms of disease, as live virus vaccines, in particular oral polio, are not recommended for children with a suppressed immune system. The oral polio vaccine should not be administered to others in the household of an HIV infected adult or child to avoid exposure to live polio virus shed by the oral polio vaccine recipient. Injectable polio vaccine is available as an alternative.

- (19) If the child's parent is not available or willing to give consent for testing or treatment and court authorization is required, the court order must specify whether the parent may be told of the child's HIV infection.
- (20) If the child or youth gives his or her own consent for testing or treatment, the child's parent is not authorized to receive related information without a signed release by the child.
- (21) The parents of other children in the foster care setting are not among the parties who have a need to know. They shall not be informed of the health status of a child who is HIV infected, except under extraordinary circumstances. In such instances the department shall not use the name of the HIV infected child. An example of when it might be appropriate is when high risk behavior, such as blood or semen exchange, has occurred between the HIV infected child and another child.
- (22) The policy of obtaining consent or a court order to disclose to parties other than the child's caregiver, the medical practitioner and the guardian ad litem shall be observed as specified in Section 381.004, F.S.
- (23) Foster care case records shall be treated as follows for confidentiality purposes:
- (a) Case narrative shall not contain reference to the child's HIV infection or AIDS. The term "suppressed immune system" shall be used instead;
- (b) Case material which discloses that the child has HIV infection, ARC or AIDS shall be kept in a "Privileged/Confidential Information" envelope used to safeguard sensitive case information;
- (c) Foster care records shall not be segregated or flagged in any way which would permit their identification as case records of HIV infected children.

- 219

- (24) Employees of the department who violate the confidentiality of the medical records of a child who has HIV infection or AIDS shall be subject to disciplinary action, including dismissal, and to criminal penalties as specified in Chapter 384, F.S.

Specific Authority 39.012 FS. Law Implemented 39.001, 39.01, 39.41, 39.45, 39.46, 381.004, 384.29, 384.30, 409.145, 409.165 FS. History—New 5-20-92, Formerly 10M-6.140.

65C-13.018 Services to Parents of Children in Foster Care.

- (1) The foster care counselor shall make diligent efforts to establish and maintain regular face-to-face contact at least once a month with the parents of placed children, excluding those children exempted by Section 39.456, F.S. Parents shall be regularly and promptly informed of their children's progress, development, health and education, unless the child has been relinquished, parental rights have been terminated, or the parents' whereabouts are unknown and this has been documented through diligent search.
- (2) The department shall inform and assist parents to exercise their legal rights and responsibilities even while intervening to protect the child and promote his well-being. The department shall assist parents in identifying and accessing legal services available within the community.
- (3) The department shall provide services as available to assist parents in:
- (a) Identifying and remedying the problems which have resulted in the separation of the family;
- (b) Understanding and meeting their children's needs, including the child's need for safety;
- (c) Maintaining continuing contact with their children; and
- (d) Selecting and working toward a realistic and timely case goal, including the possibility of permanent separation from their children if that becomes necessary.

(4) Except when expedited procedures pursuant to Section 39.464(1)-(4), F.S., are used to terminate parental rights, reunification services shall be provided as available to assist the parents of foster children in making changes that will permit a safe reunification of the family whenever possible and as quickly as possible. Services shall be focused on specific problem areas which make it unsafe to return the child home, not on general family needs. These services include evaluation and assessment; referral for mental health or substance abuse services as needed; financial, medical, employment and educational services; and assistance in problems solving within the family.

(5) The department shall document services offered, services provided and the effects of these services and shall communicate at least monthly with the parents on progress made or lack of progress. This information shall provide the basis for casework decisions and recommendations to the court.

(6) The department shall help parents understand that they are responsible to pay for the support of their child, pursuant to Section 39.41(2)(a), F.S.

(7) The selection of a placement for a child in foster care shall, subject to the availability of resources, be based upon the child's age, sex, and special emotional and developmental needs as a result of having been a child victim of abuse, neglect or abandonment, and shall also consider the child's religious identification and the special needs of a child with handicaps. Further the placement of a child into a foster or shelter home may not be delayed or denied on the basis of the race, color, or national origin of the foster parent, or the child involved. In the case of an American Indian child, placement must comply with Section 105, PL 95-608, entitled Indian Child Welfare Act which is incorporated by reference.

(8) For a period of at least six months following the removal of a child from foster care placement, excluding children who are placed in adoptive homes, the department shall provide or arrange post-placement support services, as available, to the child and family. These services shall build on the gains made by the family while the child was in care in order to assure the child's safety and the family's continued success. Where available, these support services include day care, homemaker or housekeeper services, child mental health treatment, drug or alcohol treatment, respite care, parent education, self-help groups, vocational counseling, education, preventative or reunification services.

Specific Authority 39.012 FS. Law Implemented 39.001, 39.41, 39.45, 39.46, 409.145, 409.165 FS. History—New 5-20-92, Formerly 10M-6.143, Amended 9-10-98.

65C-13.019 Administrative Review.

(1) The department shall schedule administrative reviews as necessary to ensure that each child has either a judicial or an administrative review no less frequently than every six months.

(2) Children subject to administrative review include children age 13 or older who have been in care for 18 months and are on an annual judicial review schedule. For these children an administrative review shall be held no later than six months from the most recent judicial review. Other children subject to administrative review include children who remain in foster care beyond their 18th birthday and children who have been placed in an adoptive home.

(3) Each district shall establish an administrative review panel in conformity with the requirements of Public Law 96-272, 42

U.S.C. Section 675(6), Supp. V. 1981, which is incorporated by reference.

(4) A written notice of the administrative review conference which gives the time, date, location and purpose of the conference

and which has attached a copy of the administrative review report shall be provided by the department two weeks in advance to the

parents, foster parents, guardian ad litem if one has been appointed, attorney of record, and members of the review panel.

(5) The notice shall also advise the parties of their right to attend and to bring a representative of their choice to the conference.

- 220

(6) Because the active involvement of the parent plays a central role in the timely reunification of families or the culmination

of other permanent placement plans, efforts shall be made to schedule the administrative review conference at a place and time

convenient to the parent.

(7) Children who have sufficient maturity shall participate in the conference, just as they do in court reviews. All children shall

be given an explanation of the findings and recommendations of the conference that is appropriate to their age and level of understanding.

(8) A copy of the administrative review report will be distributed to all participants at the beginning of the conference as a basis

for discussion.

(9) The chairperson of the administrative review conference shall focus the discussion on appropriateness of the goal,

appropriateness of the performance agreement or permanent placement plan, the efforts of each party to implement the agreement

or plan successfully, and the progress or lack of progress toward achieving the specified changes or accomplishments.

(10) Discussion during the conference shall include:

(a) Services provided to all parties;

(b) Progress toward the case goal;

(c) Obstacles to progress;

(d) Strategies for overcoming obstacles; and

(e) Validity of the case goal and time frames for achievement.

(11) The conference may result in the need to modify the performance agreement or permanent placement plan. In this event

the department shall:

(a) Amend the performance agreement or permanent placement plan to reflect these changes

and file the amended document with the court within 10 working days of the conference; and

(b) Request a court review within 10 working days of the conference if the parties are not in agreement as to the findings and recommendations.

(12) At the close of the conference all participants shall sign the conference report. Parties shall indicate agreement or

disagreement with the findings and recommendations; panel members shall indicate attendance only.

(13) If a parent is not present for the review, the chairperson will indicate in the space designated for the parents' signature that

parental notification or a diligent search is documented in the case file.

Specific Authority 39.012 FS. Law Implemented 39.001, 39.41, 39.45, 39.46, 409.145, 409.165 FS. History—New 5-20-92, Formerly 10M-6.148.

65C-13.020 Permanency Staffings.

(1) The department must make every effort to achieve a safe permanent home for each foster child within 12 months of the

foster care placement or within 18 months of removal, whichever comes first. The permanency staffing is a primary component in achieving this goal. The problem solving and decision-making necessary to achieve this goal are accomplished best in a group of

professionals and interested parties who have access to all the pertinent information concerning the child.

(a) If a child reaches his 11th month from foster care disposition or 17th month from removal, whichever comes first, a

permanency staffing must be conducted. The purpose of the staffing is to consider TPR and subsequent adoption as a goal. Prior to selection of this goal, the following must be ensured:

1. All of the appropriate and necessary steps to reunite the child with his parents have been taken and have failed, and such activities are documented in the child's record;
2. All possible relatives have been explored as a placement resource for the child;
3. Sufficient legal grounds exist for the department to pursue termination of parental rights;
4. Adoption placement is a viable option for the child. Adoption is a viable option for any child who has the capacity for forming relationships in a family setting and who, if of sufficient age and maturity, has not decided that he does not wish to be adopted; and
5. Needed expertise of all involved professionals is utilized in making the decision to terminate a child's ties with his family.

(b) Adoption planning must be considered in any of the following circumstances:

1. The parents have clearly and repeatedly failed to demonstrate their ability to provide a home that is minimally sufficient to protect the child's safety and well-being, despite the provision of appropriate services. A period of nine to 11 months, fewer if possible, should be used to evaluate the parents. Pursuant to Section 39.469(3)(e), F.S., for purposes of TPR, the court will not consider the parents' failure to comply with the agreement or plan as evidence of abuse or neglect if the failure to comply is due to lack of financial resources of the parent or to the department's failure to make reasonable efforts to reunify the family;
2. Expert evaluation indicates that a parental condition which has required placement of the child is not treatable or the parenting ability is permanently impaired beyond a minimally safe level for the child;
3. The child has repeatedly demonstrated his inability to respond to the supervision and care provided by his parent;
4. All biological and legal parents of the child are deceased;
5. The parents have disappeared and their whereabouts are unknown for a period of six months; or
6. The court has ordered the department to initiate TPR proceedings for a child. The department must either initiate TPR proceedings as ordered or appeal the order through appropriate legal channels.

- 221

(c) If reunification continues to be the goal, permanency staffings must be held at regular intervals until reunification has been ruled out as a goal. Plans to consider reunification efforts must be considered if one of the following circumstances exists:

1. The department has not been aggressive enough in working with the family;
2. Additional work with the family is needed before the department can pursue TPR;
3. Diligent searches have not been conducted, or they are not current within the last six months;
4. The parent has actively demonstrated the ability and motivation to complete the tasks listed on the performance agreement but has been unable to substantially complete them due to circumstances beyond his control. In addition to demonstrating ability

and motivation, the parent has demonstrated interest and concern as evidenced by calls, letters and regular contact with the department; or

5. A parent has recently become known to the department and has actively demonstrated the ability and motivation to complete the tasks listed on his performance agreement.

(d) Plans to continue in foster care must be considered only under the following circumstances:

1. Reunification and adoption have been considered and ruled out as achievable goals, and all parties agree that custody on a

permanent basis to a foster parent is an achievable goal. When this goal is selected, the child is still in foster care status and all legal

requirements remain the same. Foster parents continue to receive board payments, clothing allowance and transportation expenses.

Quarterly face-to-face visits with the foster parent and the child are required;

2. Reunification and adoption have been considered and ruled out as achievable goals, and the child desires and meets the

necessary criteria of subsidized independent living in accordance with Section 409.165, F.S.; or

3. Reunification, adoption, custody on a permanent basis to a foster parent and independent living have all been considered and

ruled out as achievable goals, and the situation of the child is so extraordinary that long-term care is considered an appropriate goal.

The Family Safety and Preservation program administrator or designee must review the case and approve the goal of long-term

care. Because every child has the right to a permanent home, the following reasons alone are not sufficient to result in the goal of

long-term care:

a. The child is attached to the foster parents who are unwilling to adopt the child. Although foster parents are the adoptive

placement of choice, if they do not wish to adopt and the child cannot be reunified with his birth family, adoption by another family

must be pursued;

b. The child's age or handicap is such that staff think that efforts to find a permanent adoptive home will be unsuccessful.

Adoption must be considered as an achievable option for teenagers and children with handicaps who cannot be reunited with birth

families;

c. The child has an on-going relationship with members of his birth family although the family members cannot assume

responsibility for the child's care. Children in this situation must be considered for placement in adoptive homes where they will be

permitted to maintain contact with significant persons from their past;

d. The child says he or she does not want to be adopted. It should be recognized that adoption is a frightening experience for

many children who have suffered repeated losses in their relationships with family members. These children must be helped to

understand the positive aspects of adoption, and the child's case record must document the casework services provided to assist the

child with this issue. These services should include individual or group exposure to other children of the same age who have had

positive adoption experiences, as well as other appropriate casework; or

e. Parental rights have been terminated, and it becomes evident that adoption is not an achievable goal for the child. A

permanency staffing must be conducted to ensure that the child has:

(I) Had the benefit of local recruitment activities;

(II) Been referred to the state adoption exchange and included in the statewide photo listing; and

(III) Been referred to regional and national adoption exchanges and included in regional and national photo listings.

(2) The permanency staffing will be chaired by a foster care or adoption supervisor or program specialist. The staffing will be

attended by the following individuals:

- (a) Foster care supervisor;
- (b) Foster care counselor responsible for the case;
- (c) Adoption supervisor;
- (d) District program specialist;
- (e) Child's foster parent or substitute caretaker;
- (f) Guardian ad litem, if one has been appointed; and
- (g) Involved professionals and district legal counsel, if available.

(3) Permanency staffing dispositions are as follows:

- (a) Initiate termination of parental rights proceedings and subsequent adoption planning;
- (b) Change the goal from adoption to another goal;
- (c) Pursue alternate permanency goals, i.e., custody on a permanent basis to a foster parent, independent living or long-term foster care; or
- (d) Continue to pursue reunification as a goal.

(4) Children awaiting adoption placement must receive a quarterly case staffing with the ARS counselor to assess the needs of waiting children and families. Every staffing should result in:

- 222

- (a) A clear understanding by each participant of the status of each child's case and the progress made towards accomplishment of a permanent placement for that child; and
- (b) A clear understanding by each participant of specific duties to be performed by the next staffing, if applicable.

Specific Authority 39.012 FS. Law Implemented 39.001, 39.01, 39.41, 39.46, 409.145, 409.165 FS. History—New 5-20-92, Formerly 10M-6.150.

65C-13.021 Post-Placement and Protective Supervision.

(1) The post-placement supervision case plan must be completed prior to the judicial review in which reunification is

recommended. The effective date is the date custody is changed to the parent.

(2) If the court returns custody to the parent contrary to the department's recommendation, the post-placement supervision case plan must be completed within five working days of the court hearing.

(3) The case plan will include:

- (a) The reasons for the child's removal and goals and activities necessary to remedy any of those initial problems that remain;
- (b) Routine health care as well as follow-up care for physical health, mental health or substance abuse service needs that have been identified;
- (c) Specific provisions, that comply with requirements specified in subparagraphs 65C-13.021(8)(a)1.-6., F.A.C., when substance abuse by the parent or significant other in the home, such as a paramour, contributed to the need for foster care or when substance abuse later becomes a factor contributing to the need for supervision;
- (d) A specific provision for child day care for children meeting the criteria specified in paragraphs 65C-13.129(7)(a)-(d), F.A.C.;
- (e) Specific provisions regarding visual observation as specified in paragraphs 65C-13.129(9)(b), (c), F.A.C.; and
- (f) A specific provision that families who receive or are eligible for food stamps or public assistance must maintain eligibility

status by completing all required documents and by keeping food stamp and economic services offices informed as requested.

(4) In developing the case plan the counselor must:

- (a) Be aware of family systems issues and how the child's re-entry into the family will affect family functioning;
- (b) Write the plan so that the parent will understand all goals and activities;
- (c) Ensure that the plan is time-limited with measurable outcomes;
- (d) Discuss the child-specific needs with the foster parent to assure that the child's special needs are included in the plan;
- (e) Engage providers, such as Alcohol Drug Abuse and Mental Health, ADM, providers; County Public Health Units, CPHU; Children's Medical Services, CMS; guardians ad litem, GAL, etc., in the development of the case plan; and
- (f) Include the name of the person responsible and the time frame for each task to be completed.

(5) The case plan may be filed with the judicial review social study when the department recommends reunification, or it may be filed only in the case record with a copy to all parties.

(a) The case plan will not expire but must be updated as indicated.

(b) Post-placement supervision must continue for at least six months; however, it may be extended when approved by the court. Specific rationale must be provided to the court when requesting an extension of supervision. That rationale must be linked to task accomplishment and risk assessment.

(6) Components of in-home supervision are similar to supervision in a foster home in that they involve regular visitation and contact with parent and child; exchange of information with the parent; support and guidance as needed; help with the use of community resources; and responsibility for evaluating the child's progress. The counselor should be aware of the child's development, school attendance and adjustment, health and medical care, public assistance eligibility status, day care arrangements, treatment plans and achievements, nutrition, recreation, relationships in the family, relationships with peers, and feelings about the counselor.

(a) The Family Safety and Preservation counselor shall have at least one home visit each month and at least one face-to-face contact monthly with each child under supervision and with the parent or relative who has assumed primary responsibility for the child's daily care and supervision.

(b) The perpetrator, if residing in the home but not assuming primary responsibility for the child's care, shall also be contacted at least monthly by the counselor, either face-to-face or by telephone.

(c) The Family Safety and Preservation supervisor shall schedule counselor visits that exceed the minimum requirements based on conditions in the home, the condition and needs of the child, the level of risk to the child, the level of cooperation of the parents or relatives, and any other factors that warrant additional safeguards for the child.

(7) Children age five and under who are determined to be at high risk for neglect or abuse according to the most recent risk assessment must be placed in child day care, including early childhood or pre-school programs, unless they are currently attending kindergarten or school. As an alternative to child day care, in-home programs such as the homemaker or intensive crisis counseling program may be utilized. The conditions below apply to the child day care requirements.

(a) Day care or alternative services must begin within five working days of the child's return home.

(b) Day care must be provided at least three days per week, or the in-home service must be provided at least two days per week.

Each day of service must comprise three hours or more.

- 223

(c) The provision of day care in a relative or non-relative home is acceptable if the relative or non-relative is cleared through

the abuse registry and passes a local law enforcement criminal record screening. In addition, the Family Safety and Preservation

counselor must visit the home of the relative or non-relative and document in the child's case record that the day care arrangements

are appropriate for the child. If the home of the relative or non-relative meets the definition of a family day care home, it must be

licensed or registered prior to using that home for day care.

(d) An absence from day care of more than two days is to be reported immediately by the provider, whether or not the parent or

guardian has provided an explanation to the provider. Such an absence exists if the child does not appear at a service site, regardless

of where the service is provided, for over two consecutive scheduled days of service, and the provider had no advance knowledge

from the Family Safety and Preservation counselor of a plan for the child to be absent during this period.

(e) Special circumstances may exist in some high risk cases that clearly do not need the type of services or the specified

frequency or intensity of services required. The district Family Safety and Preservation program administrator or designee for

foster care services may exempt cases where there is clear documentation in the case file of the circumstances surrounding such

cases. The exemption must be documented in the child's case record.

(f) The foster care counselor will work with the child's family to determine which service will be most appropriate and

beneficial for the child and family and will assist the family to make the necessary arrangements. These arrangements include:

1. Identifying and contacting a provider;

2. Applying for services;

3. Determining through abuse registry and local law enforcement criminal record screening whether a friend or relative is

acceptable to provide care;

4. Determining if a relative or non-relative home must be licensed or registered as a family day care home;

5. Scheduling and assisting the child to receive required medical exams and immunizations; and

6. Arranging for any necessary daily transportation to the day care center or other service site.

(g) Most of the children will probably be placed in a subsidized child day care program. The specific requirements the parent

must meet for a child to be enrolled in subsidized child day care are as listed below:

1. The foster care counselor must submit a written referral to the day care central agency;

2. The family must complete the application for subsidized child day care services;

3. At least one parent or guardian must review and sign the department's child care facility brochure or an equivalent brochure

prior to or at the time of the child's enrollment. This brochure is available from the day care provider; and

4. The child must have a current student health examination certification which can be obtained at an EPSDT screening.

(h) Once the child has begun receiving the child care or alternative service, the counselor should perform a new risk assessment

to determine if the level of risk to the child has been reduced.

1. This risk assessment should be performed at least 30 days after the child begins receiving the services so the counselor can

determine if the parent is cooperating with the arrangement and whether the service is having the desired effect.

2. If the reduction in risk is determined not to be substantial enough to ensure protection of the child, additional services or

requirements for the family and child should be considered.

3. If the reduction in risk is such that the child is not at high risk without child day care or alternative services, the requirement

is no longer mandatory but should be encouraged if it is a positive experience for the child.

(8) Children may be returned from foster care to families where substance abuse by the parent or a significant other contributed

to the need for removal and subsequent placement in foster care. Substance abuse may also be identified as a problem after

reunification. Parental abstinence from controlled substances contained in the various schedules of Section 893.03, F.S., must be

maintained and verified in order to assure protection of the child.

(a) The Family Safety and Preservation counselor and the substance abuse treatment provider must agree to the tasks and

expected outcomes of the post-placement supervision case plan. The agreement will include reference to the following

requirements. The Family Safety and Preservation counselor must recommend that these requirements be included in the court

order which places the child on post-placement supervision:

1. The drug screen used in the urinalyses must include at least the drug or substance for which there is evidence of use by the

substance abuser. If there are indications at a later date that an additional drug or substance is being used, it should be included in

the urinalysis screen;

2. The ADM provider will inform the foster care counselor of the frequency and schedule of substance abuse treatment, of

urinalyses, and of any subsequent changes in the frequency or schedule;

3. The ADM provider will inform the foster care counselor and the CPHU nurse, if involved, within 24 hours of the parent's or

significant other's positive urinalysis, failure to attend a scheduled treatment appointment, or failure to successfully complete the

substance abuse treatment program. Follow-up written notification will be sent to the foster care counselor within two working

days;

4. If the substance abuse treatment provider suspects that a client may be abusing or neglecting the dependent child, the

provider must immediately report this suspicion to the abuse registry and must verbally notify the foster care counselor and the

community health nurse case manager within 24 hours of this occurrence. Follow-up written notification must be sent to the foster

care counselor within two working days;

- 224

5. The substance abuse treatment provider will follow the same procedure outlined above when the provider is concerned that

the client may be failing to make sufficient progress in treatment, relapsing, or demonstrating any other behaviors that warrant

further supervision; and

6. The plan will specify the substance abuse treatment program to be attended, the number of required urinalyses, the expected

outcomes of the treatment and the urinalyses, and the specific actions the department will take if one or more of the urinalyses is

positive, if scheduled treatment appointments are not kept, or if the treatment program is not successfully completed. It should be

clearly stated that if the substance abuse treatment program is not successfully completed, if the parent or significant other is not

regularly attending treatment sessions, if positive test results are received and if it is determined that the children are in immediate

danger, the children will be removed from the home. If it is determined that the children are not in immediate danger and it is determined that the parent or significant other has failed to meet the above stated requirements, an immediate staffing will be held to consider removal of the children from the home as well as other alternatives.

(b) The Family Safety and Preservation counselor has the following supervision responsibilities related to families where

substance abuse is a factor of dependency:

1. When the foster care counselor is notified that a client has had a positive urinalysis, has failed to attend scheduled treatment appointments, or has failed to successfully complete the substance abuse treatment program, the counselor will make an immediate on-site assessment to determine the safety of the child, the need to remove the child from the home, and the need for additional services. The foster care counselor will immediately verbally advise the substance abuse treatment provider and if one is involved the CPHU nurse of the results of the on-site assessment and of any other actions taken so that joint efforts can ensure abstinence or reinvolve the client in the substance abuse treatment program. The counselor will send the written information within two working days;

2. Within two working days of receiving the written notification from the substance abuse treatment provider, the foster care counselor will notify the court in writing of the client's failure to comply with the provisions of the court order. Notification will also include an assessment of the client's progress to date and a recommendation for an amended court order, if deemed appropriate. In addition to giving the written report, the provider may be requested to appear before the court to provide testimony in person;

3. Before completing any documents for the court or testifying in court, the foster care counselor will check with the substance abuse treatment provider to ensure that the information given to the court regarding the substance abuse treatment is accurate and up-to-date;

4. Urinalysis results, treatment attendance and the results of attendance at the substance abuse treatment program will be included in regular six-month reports to the court; and

5. When substance abuse later contributes to the need for additional supervision, the case plan will be modified to stipulate a requirement for random urinalyses and satisfactory completion of a substance abuse treatment program. The foster care counselor will petition the court to require court ordered treatment and random urinalyses.

(9) Supervisory visits involving children who either live in the home of the perpetrator or to whom the perpetrator has or is suspected to have unsupervised access will include a visual observation of the child to note any changes in the child's conditions, particularly if there are visible marks on the child while fully clothed. If the child has visible marks while fully clothed, an assessment shall be made to verify the nature of the injury.

(a) The frequency of a visual observation is as follows:

1. At every visit for children age four and under; and
2. As needed for children age five and older, based on observation of the child's interaction with the adult caretaker and the child's response to questioning.

(b) When there is reason to believe it is necessary to observe the child in less concealing clothing or unclothed, the counselor must request the parent or caretaker to assist in disrobing the child. There are a number of restrictions which apply in situations where the child must disrobe. They are as follows:

1. A child who is severely ill should be seen immediately by a physician;
2. A counselor of either sex may conduct the visual observation of a child age one and under;
3. A counselor of the same sex must conduct the visual observation of a child age two through four;
4. Medical or health professionals only may examine children age five or older;
5. If the child's history involves sexual abuse, the counselor shall conduct the visual observation as required; however, if there are indications of any abuse that warrant disrobing, a screening must be conducted by a medical or health professional;

(c) If the child's history involves physical abuse, it is critical for the counselor to be alert to any indications of further abuse which may require removal of the child's clothing;

(d) If the child's history involves neglect, it is necessary for the counselor to be observant and alert to the need for removal of the child's clothing since neglected children are also at risk for abuse.

(e) If the child's parent refuses to allow the removal of the child's clothing, the counselor shall take one of the following actions:

1. The counselor and the parent may take the child to a physician or hospital emergency room for a physical examination by a medical professional. If the examination discloses the presence of injuries which are suspected to be non-accidental, the counselor must report to the abuse registry immediately.

- 225

2. The counselor may take the child to a physician or hospital emergency room for a physical examination by a medical professional. If the parent will not consent, the counselor should be suspicious of abuse. The counselor must then decide whether to take the child into protective custody and take the child to a physician, the child protection team or a hospital emergency room in accordance with Section 39.401(1)(b), (c), F.S. If the examination discloses the presence of injuries which are suspected to be non-accidental, the counselor must report to the abuse registry immediately.

(10) A risk assessment must be completed at least every six months from the date of reunification of whenever factors become

known to the counselor which might affect the level of risk to the child.

(11) If the counselor discovers that the family has moved without notifying the department, the following actions must be taken:

- (a) A diligent search must be initiated immediately. The counselor will contact the utility company, the child's school, neighbors, known relatives, directory assistance, employer and other appropriate sources;
- (b) A statewide alert through the abuse registry must be initiated; and
- (c) The court should be notified within two working days that the family has absconded. A staffing which includes individuals selected by the district Family Safety and Preservation program administrator or designee will determine whether to request that the court issue a pick-up order;

(12) At the end of the six month period of supervision, the department shall:

- (a) Evaluate, with the family, their adjustment following return of the child and their progress toward completion of tasks in the case plan;

(b) Assess any continuing safety concerns by conducting a risk assessment; and

(c) Prepare a report to the court which addresses the issues noted in the post-placement supervision case plan and the outcome of a current risk assessment and provide a recommendation for case termination or extension of supervision. The report should also contain reports from all service providers and other documentation to support the recommendation.

(13) When a child leaves foster care for a temporary relative placement, the counselor will supervise the placement as a foster home placement is supervised. The following supervision activities will take place:

(a) Maintain monthly face-to-face contact with the relative and the child;

(b) Comply with and monitor parents' compliance with the performance agreement or the permanent placement plan;

(c) Recommend reunification when parents comply with their performance agreement or permanent placement plan;

(d) Recommend long-term relative care if the parents fail to comply with their performance agreement or permanent placement plan and if all the criteria specified in Section 39.41(1)(a)a. and b., F.S., are met.

(14) The department shall not discontinue active post-placement supervision until the receipt of a court order which releases the department from further supervision.

(15) A foster care counselor may be assigned a protective services case when one or more siblings in a sibling group are in a foster care placement. The following apply to those situations:

(a) The counselor will provide monthly face-to-face contact;

(b) The counselor will be thoroughly familiar with all supervision activities specified in Chapter 65C-11, F.A.C., and will assure that they are carried out; and

(c) Only foster care counselors who have been trained in protective services will be assigned a protective services supervision case. The OPA will decide the case assignment to ensure provision of the required supervision.

(16) When there is a new abuse or neglect report in a post-placement supervision case, the following conditions apply:

(a) All new reports of abuse or neglect of active clients will be investigated by a protective investigator with the assistance, as available and appropriate, of the foster care counselor. If the foster care counselor is not available, the commencement of the investigation will not be delayed. The protective investigator may request the foster care counselor's assistance to reduce the trauma to the child and family during the protective investigator's initial contact with the family. This request does not require the foster care counselor to be available to accompany the protective investigator on immediate response reports or on reports investigated outside of the foster care counselor's normal work schedule;

(b) If protective custody is warranted for the child because of the new report, it will be the responsibility of the protective investigator to take the child into custody and to assist the department's attorney in preparing for the detention hearing. This responsibility includes arranging a placement, having the child medically screened, and when appropriate, ensuring the child's attendance at the shelter detention hearing. The foster care counselor will assist in replacement of the child and will assume responsibility for services;

(c) When there has been a material violation of a court ordered condition of supervision, a new report is not made and an investigation is not performed. The department's attorney is to be immediately notified when there is a change in the current

environment which places the child in danger. In these instances, the foster care counselor shall take the child into custody, if necessary, and shall be responsible for working with the attorney regarding necessary court activities for the case. The detention order must contain a finding which states that it is “contrary to the welfare of the child to remain in the home” and that “reasonable efforts have been made to prevent removal;”

(d) The protective investigator and the foster care counselor will participate in staffings with the department’s attorney and others regarding further judicial action. It is the responsibility of the department’s attorney to draft and file the dependency petition;

and

- 226

(e) When the department’s recommendation for disposition is agreed upon, the foster care counselor, with information and assistance from the protective investigator, will be responsible for assisting the department’s attorney to case disposition.

Specific Authority 39.012 FS. Law Implemented 39.001, 39.41, 39.45, 39.46, 409.145, 409.165 FS. History–New 5-20-92, Formerly 10M-6.152.